2010 Washington, D.C.

Title V Needs Assessment

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH
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1. Executive Summary.

1.1. Introduction.

Every five years, the District of Columbia, like all states receiving a Title V Maternal and Child Health Services Block Grant, is required to complete a comprehensive needs assessment to determine gaps in health status and health-system capacity for the maternal and child health (MCH) population. As a part of the current process, quantitative analysis of Title V health indicators was undertaken, and focus groups and key informant interviews were conducted. The D.C. Department of Health's Community Health Administration (CHA), which administered Title V programs in the District, contracted with InterGroup Services, Inc. (IGS), a Baltimore-based consulting company, to conduct this needs assessment under the guidance of a group of CHA personnel.

1.2. Demographic Changes Since the Previous Needs Assessment.

According to the U.S. Census Bureau, the population of the nation's capital has grown steadily though not dramatically since 2000, with the most recent estimate (2009) putting the District's total population at 599,657. This represents a growth rate of about five percent over nine years. The Census Bureau's annual demographic estimates show that in 2008 the District's population was 54 percent African-American. That percentage reflects a relative decline since the 2000 census. Caucasians (40 percent) and Asians (4 percent) are rising as a percentage of the overall District population. Less than two percent (1.6) of District residents reported being two or more races while 8.6 percent were Hispanic or Latino (any race).

Washington, D.C. is divided into eight major political jurisdictions or wards. Though each ward contains a comparable number of residents, the makeup of the populations within the wards varies dramatically. According to the District Office of Planning, in 2008, Wards 2 and 3 were home to the largest percentages of white residents, and Wards 7 and 8 were most prominently African-American. Ward 2 had the highest percentage of Asians and Pacific Islanders (8.3 percent), while the largest percentage of Hispanics (24.8) resided in Ward 1.

1.3. Needs Assessment Process and Methodology.

Various methods of data collection were utilized in completing this needs assessment. Some were quantitative, such as examining health-care trends and reports or MCH-related survey results, while others were qualitative, such as obtaining the opinions of District residents who use Title V services or those who work in the MCH field. The D.C. Department of Health (DOH) and its contractor, InterGroup Services, Inc. (IGS), identified and contacted organizations involved in the MCH field. IGS asked representatives of each organization to assist in identifying and recruiting participants from its client ranks for focus groups to be convened. DOH likewise identified MCH experts whom IGS interviewed. IGS asked these "key informants" questions previously devised in consultation with DOH. Interviewees represented large national organizations and hospitals as well as small grassroots outfits. Individuals and organizations directly involved with or impacted by Title V services are referred to as "stakeholders" in this report.

1.4. Title V Health Indicators.

Using the nine community-level priorities identified in the 2005 D.C. Title V needs assessment, the 2010 analysis was undertaken this year to determine the status of those same health issues in the District. In addition, further indicators were developed based on the qualitative findings of the focus groups and key-informant interviews. The results of this analysis were used to guide the identification of priorities for Title V programs to address over the next five years. Similarly, stakeholder input guides DOH in finalizing the new priorities.

The areas of the greatest concern involve indicators that have both worsened over time for residents of Washington, D.C. and were worse in the District, as of the most recent measurement, than they were in the nation as a whole. These indicators include: infant mortality, obesity among students, students involved in a physical fight over the past year, student reporting that they have ever had asthma, and families of children with special health-care needs (CSHCN) reporting that they do not have engage in coordinated, ongoing comprehensive care in a medical home.

1.5. Focus Groups.

Ten focus groups were conducted throughout the District of Columbia to gather feedback from both service recipients and maternal- and children-health professionals. The areas of concern identified through these focus groups were more programmatic in nature. Focus-group participants identified the temporary assistance for needy families (TANF) program as an area in need of improvement when discussing services for pregnant women, mothers and infants. When the topic turned to children and adolescents, participants noted the lack of recreational activities, and the perceived lack of parenting skills among young parents was also frequently noted. For CSHCN, the individual educational plans, as administered by the D.C. public school system, were commonly stated to be inadequate, and respondents also noted that children with special needs were too often misdiagnosed or mistreated.

1.6. Key Informant Interviews.

In addition to the input garnered by focus groups including MCH professionals, 10 telephone interviews of area experts were conducted. In addition to confirming many of the concerns raised in the focus groups, these interviewees identified eliminating ineffective processes and bureaucracy, involving the community and encouraging dialogue, and only funding quality programs as means of improving the effectiveness of Title V programs in the District.

1.7. Summary of Strengths.

Focus-group participants and key informants were asked to identify the services/initiatives that they felt were the most successful for the MCH population, focusing on the subpopulations: pregnant women, mothers and infants; children and youth; and children with special health-care needs. Both sets of participants reported similar programs that are working well to serve the maternal and child-health needs of the District. The Women, Infants and Children (WIC) program, Healthy Babies and the Healthy Start programs, as well as the breastfeeding centers, were considered to be strengths by the pregnant women, mothers and infants groups. For children and youth, strengths were the immunization program and District support of the Children's National Medical Center. As for children with special health-care needs, the advocacy work of Health Services for Children with Special Health Care Needs, Inc. was applauded. Praise was also given to the recreational centers at Mary's Center and the Latin American Youth Center.

1.8 Summary of Challenges.

Focus-group participants and key informants were also asked to identify the services, initiatives and issues that they felt were challenges for the MCH population, focusing on the three subpopulations. The pregnant women, mothers and infants groups found that access to care was an issue, along with a lack of parenting skills. For children and youth, the challenges included a lack of recreational services for youth as well as delay in identification of developmental challenges. There is also no support for parents to care for their children. For children with special health-care needs, the main challenge was not being diagnosed early for developmental disorders or receiving treatment/help quick enough to reverse a disorder. There are few schools or programs to deal with delays. And there is a lack of transition services for older CSHCN.

Exhibit 1 **Health Indicator Progress Summary Since 2005**	**Changed for the Better (+/- 5%)**	**Changed for the Worse (+/- 5%)**	**Minimal or No Change (< 5%)**
Pregnant Women, Mothers and Infants			
Low Birth Weight Live Births			X
Preterm Live Births		X	
Births to Teens (Ages 15-19)		X	
Women Entering Prenatal Care in the 1st Trimester*			X
Perinatal Mortality (Including Fetal Deaths)	X		
Smoking During Pregnancy	X		
Alcohol Use During Pregnancy	X		
Infant Mortality Rate			X
Newly Reported Chlamydia Cases Among Women	X		
Newly Reported Gonorrhea Cases Among Women			X
Children and Adolescents			
School based Oral Health Treatments Among 2 and 3rd Graders	X		
School based Sealants Among 2nd and 3rd Graders	X		
Obesity Among Students		X	
Students Getting 60 Minutes of Exercise Per Day	X		
Students Consuming Fruits/Vegetables 5 or More Times Per Day			X
Students Feeling Safe in School			
Percentage of High School Students in a Physical Fight		X	
Percentage of High School Students Who Carried a Weapon or Gun		X	
Child Victimization Rate (Includes Neglect, Physical Abuse, Medical Neglect and Sexual Abuse)*			X
Reported Cases of Gonorrhea Among Youth (Ages 15-19)		X	
Reported Cases of Chlamydia Among Youth (Ages 15-19)		X	
Condom Use Among High-School Students		X	
Students with Lifetime Asthma		X	
Percentage of Children Under Age 6 Tested for Lead*		X	
Percentage of Children Under Age 6 with EBLLs*		X	
Children with Special Health-care Needs			
Families of CSHCN claiming to have adequate private and/or public insurance**	X		
Families of CSHCN claiming unmet needs for specific health care services**	X		
CSHCN without a usual source of care (or who rely on the Emergency Room)**		X	
Families claiming community based services are organized so they can easily use them**	X		
Families of CSHCN claim to receive coordinated, ongoing, comprehensive care within a medical home**		X	
Families of CSHCN claim to partner in decision making at all levels and are satisfied with the services they receive**			X

The status of each of these health indicators was evaluated based on the percentage change from 2005 (the year of the previous Title V Needs Assessment) to 2007 except where noted.

** Percentage change calculated from 2005 data and 2006 data.*
*** Percentage change calculated from 2001 data and 2006 data.*

General challenges included a lack of school-based programs and population overly dependent TANF (Temporary Assistance for Needy Families). There is also a lack of specialty care in the District. There is also held to be a lack of adequate translation services, and non-English speakers contend that they treated poorly in hospitals. Medicaid recipients feel similar sentiments. Last, a

number of focus-group participants claimed that there is a lack of attention to support male involvement in health of the family.

1.9. Community Priorities.

The results of the indicator analyses, focus groups and key-informant interviews were presented to participants of a community forum; the outcome of this forum was a list of recommended priorities for the D.C. Department of Health Title V program. The top five recommended priorities were to reduce unintended pregnancies/teen births, decrease infant mortality, increase knowledge of available services, improve the efficiency of special health-care needs diagnosis in schools, and improve access to medical services.

1.10. Conclusions.

Quantitative and quantitative research showed that the statistics pertaining to preterm births and fruit and vegetable consumption by students have both deteriorated over time, along with changes in early prenatal care, student perceptions of school safety, child victimization, reported gonorrhea and chlamydia, and CSHCN families reporting that youth receive the necessary services to adequately transition to adulthood. The indicators that were of the greatest concern were those that have worsened over time and were worse in the District, as of the most recent measurement, than they were in the nation as a whole. These indicators include: infant mortality, obesity among students, students involved in a physical fight over the past year, students reporting that they have ever had asthma, and CSHCN families reporting that they do not have engage in coordinated, ongoing comprehensive care in a medical home.

1.11. Future Directions.

There are several ongoing initiatives underway in the District to address maternal and child health needs and to facilitate the coordination of efforts. These initiatives bring together community leaders from neighborhoods, local organizations, clinical institutions, and government agencies to share ideas and formulate strategies to better coordinate services. The Statewide Commission on Children, Youth and Families consists of leaders of District government agencies, including the Department of Health, convened by the Executive Office of the Mayor. The priorities that have emerged from recent meetings include improving awareness of and coordination of supportive health and educational services for children. Secondly, the Office of the Deputy Mayor for Education also convened (and continues to convene) focus groups throughout the District for community stakeholders, including representatives from CHA, to discuss issues around early childhood; healthy children and youth with special health care needs; and parent/community involvement and communication. Identified areas for improvement include awareness of and linkages to services, coordination of services, connection of youth to educational and employment opportunities, and accessibility and quality of services. In addition, the entire state Title V application narrative was e-mailed to the Children with Special Health Care Needs Advisory Board and all 60 community forum invitees for review along with instructions and comment sheets. The instructions asked reviewers to focus on the state priorities and to offer feedback.

The other important sources of data which CHA utilized to identify maternal and child health needs in the District were the RAND Corporation's 2009 report, *Health and Health Care Among District of Columbia Youth* (RAND 2009) and the National Survey of Children with Special Health Care Needs' web-site data (NSCH 2007).

The RAND Corporation's *Health and Health Care Among District of Columbia Youth* report identified particular health conditions as priorities due to their prevalence and/or the patterns of health care associated with them. The leading priority health conditions for youth in the District

according to this report are asthma and mental-health conditions such as mood, behavioral and developmental disorders.

1.11.1. Asthma.

Asthma was one of the top 10 most prevalent qualifying conditions among children enrolled in the Health Services for Children with Special Needs (HSCSN) program, according to the RAND study (RAND 2009:126). The statistics cited in this needs assessment show 26.1 percent of D.C. report having had asthma at some point in their lives, compared to 20.3 percent nationally (CDC 2005b, 2008v, 2008w). Children with asthma use substantial hospital-based services. "For example," says RAND, "asthma contributed to between 11 and 16 percent of inpatient hospitalizations in 2007 among all District youth ages 0-13, and asthma was one of the most common conditions associated with ACS-IP hospitalizations among youth ages 0-17" (RAND 2009:126). (ACS-IP stands for ambulatory care/sensitive inpatient hospitalization.)

1.11.2. Mental-health Conditions.

Among children in the Health Services for Children with Special Needs program, almost two thirds were for mental-health or developmental disorders. Among children on Medicaid (managed care and fee for service), between 4 and 14 percent of enrollees, respectively, who use services have a mental health disorder or developmental delay. Says the RAND study, "Mental health conditions contributed to 13-14 percent of inpatient stays among those ages 5-17" (RAND 2009:xix).

There are several in health-care differences between the District and the nation. The National Survey of Children's Health (NSCH 2007) emphasizes that in the District there is a need to focus efforts on improving: the coordination of comprehensive care, access to family-support services, and the transition of youth to adult health care, work and independence.

The U.S. Centers for Disease Control and Prevention's 2010 *Breastfeeding Report Card* indicated that the elements of breastfeeding-friendly communities are measured through support from birth facilities, health professionals, state legislation and public infrastructure (CDC 2010). The District of Columbia does not meet the Healthy People 2010 goal for breastfeeding initiation; however, D.C. does have a "maternity practices in infant nutrition care" score that is above the national average. The District is low on the percentage of births occurring at facilities designated as "baby friendly."

The National Alliance to Advance Adolescent Health recently conducted focus groups with low-income adolescents with special needs and their parents to identify strengths and barriers to transitioning. Unpublished data from this research shows that the subject of health-care transition was a new topic for D.C. teens and parents alike in the focus groups, even among older teens. Most, however, appeared to be informed about education transition. Results indicated the need for ways to close the "knowledge gap" early in adolescence and to include a variety of face-to-face, Internet-based and informational strategies involving teens and parents.

In addition to assessing needs in the District, CHA assessed its internal capacity to provide services and to support systems of care through a CAST-V assessment conducted by IGS. The CAST-V report is not included as part of this needs assessment.

The final state priorities for D.C. were determined through analysis of the information compiled from the many sources cited in this report. The ranked list of priorities from the final event of the needs assessment project, a large community forum (see chapter 7), served as the starting point in determining priorities. Upon closer examination of the list, many of the top 10 priorities were

determined to be intermediate outcomes towards addressing an overarching primary priority. For example, recommendations to increase access to prenatal care and home-visiting programs are also strategies to decrease infant mortality, so CHA decided to select infant mortality as the priority with the knowledge that prenatal care and home visiting are potential intervention areas to address that need. Priorities from the community forum list were also modified to better reflect what the Department of Health has authority to influence. The Department of Parks and Recreation or D.C. Public Schools are in a better position to increase recreational opportunities for youth, for example, but DOH can effectively promote physical activity as recreation. Modifications in ranking and additions of new priorities were made to the Community Forum list based on prevalence and morbidity data. Asthma, mood disorders and sexually transmitted infections were not on the initial list, but the data from the RAND report and from the needs-assessment date-gathering process indicate that these issues disproportionately burden the District's children and youth, so they were included as Title V priorities.

The final list of D.C. priorities is as follows:

1. Decrease infant mortality.

2. Enhance nutrition and increase physical activity for children and youth through increased access to healthy foods and physical activity opportunities and through breastfeeding promotion.

3. Reduce teen pregnancy.

4. Increase access to medical homes for CSHCN and support coordinated, family-centered systems of care.

5. Reduce morbidity due to asthma among children and youth.

6. Reduce intentional injury among children and youth.

7. Improve oral health among children, youth and pregnant women.

8. Reduce sexually transmitted infections in adolescents.

9. Increase lead screening for children under six years of age.

10. Improve surveillance and monitoring of maternal and child health.

The D.C. Department of Health is working on a single action plan for the District that will be ready in summer 2011, which will include the Title V action plan.

2. Introduction.

2.1. What is Title V?

The Title V Maternal and Child Health Services Block Grant is a federal grant program that provides funding to support activities that improve the health of pregnant women, children, adolescents, and children and youth with special health care needs. Every five years, states are required to complete a comprehensive needs assessment to determine gaps in health status and health-system capacity for the maternal and child health (MCH) population. The assessment includes research of public health and other data, surveys of state and local stakeholders, and an assessment of the state system's ability to effectively deliver interventions and programs.

2.2. Needs Assessment Process.

Several means of data collection were utilized in completing this needs assessment. Some of these were quantitative, such as examining health-care trends and reports or MCH-related survey results, while others were qualitative, such as obtaining the opinions of District residents who use Title V services or those who work in the MCH field. An overview of each component is presented below.

2.2.1. Indicator Analysis.

Using the nine preexisting community-level priorities from the most recent needs assessment in 2005 as a starting point (DOH 2005), a thorough statistical analysis was undertaken in an effort to determine the District's success in positively impacting these previously identified needs. In addition, further indicators were developed based on the qualitative findings of the focus groups and key-informant interviews. The results of this statistical examination of MCH health care in the District can be found beginning on page 23.

2.2.2. Focus Groups.

In order to gain a better understanding of the experiences of D.C. residents who may rely on or have intimate knowledge of Title V-funded services, 10 focus groups were held throughout the District — 8 community focus groups and 2 focus groups for MCH professionals. In all, over 100 individuals contributed their opinions on the status of Title V services in the District. A synopsis of the focus groups and the information gathered in them can be found beginning on page 47 of this document.

2.2.3. Key Informant Interviews.

In addition to seeking feedback from the community through focus groups, 10 telephone interviews were conducted with MCH experts working in the District. A detailed synopsis of the information gathered in these key informant interviews begins on page 59 of this document.

2.3. Outcomes.

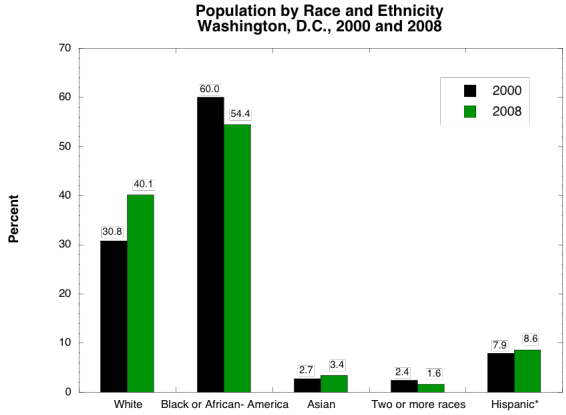
Based on the findings of the research conducted during the needs assessment process, the District is mandated to identify new priorities for Title V programs to address over the next five years. To facilitate this process, a community forum was held to discuss the outcomes of the indicator analysis, focus groups and key informant interviews. The results from the 2010 Community Health Forum (page 65) will provide direction to the Washington, D.C., Department of Health as it finalizes the new priorities for the Title V block grant.

3. Washington, D.C., in Context.

3.1. Demography.

Before turning to the particulars of the needs assessment, it is important to grasp the demographic, economic and health context that Title V operates under in Washington, D.C. According to the U.S. Census Bureau, the population of the nation's capital has been growing steadily though not dramatically since 2000 (population: 572,059), with the most recent estimate (2009) putting the District's total population at 599,657 (BC 2008c). This represents a growth rate of 4.8 percent over nine years. Over this period the age and educational attainment of District residents have remained similar, while the racial and ethnic composition suggests that the area is slightly more diverse today than it was in 2000.

Figure 1

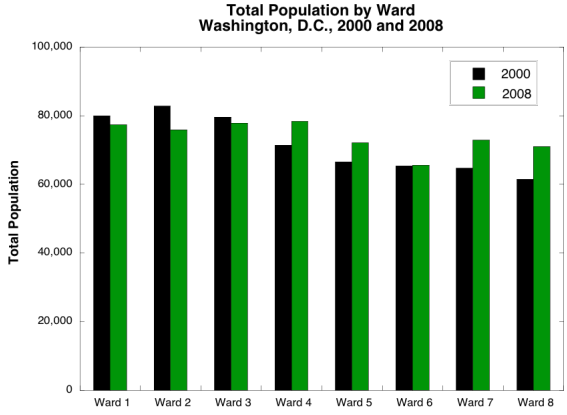


* Hispanic or Latino origin of any race.

Source: U.S. Department of Commerce, Bureau of the Census 2000, 2008 (BC 2000b, 2008c).

As shown in figure 1, annual estimates by the U.S. Census Bureau show that, in 2008, the majority of the District's population was African-American (54.4 percent).[1] At just over 40 percent, whites were the second largest racial group residing in the District. The next most prevalent groups were Asians/Pacific Islanders (3.4 percent) and the less than two percent (1.6) of District residents that reported being two or more races. With respect to ethnicity, 8.6 percent of the District's residents (of all races) were Hispanic. In both absolute and relative (to other racial groups) terms, there were fewer blacks/African-Americans in Washington, D.C., in 2008 than in 2000. While the population share of the District's blacks in 2008 was 9.3 percent lower than it was 2000, there were substantial percent increases in the population shares of both whites (30.2 percent) and Asians (25.9 percent). The percentage of the District's Hispanic population also increased 8.9 percent (from 7.9 to 8.6 percent) since 2000. A closer look at Washington, D.C.'s wards presents another perspective of the District's racial and ethnic composition.

Figure 2



* Rates based on 2000 and 2008 estimated populations, using block group data provided by Caliper Corporation to derive ward data.

Source: U.S. Department of Commerce, Bureau of the Census. 2000; D.C. Office of Planning, State Data Center 2000 and 2008 (BC 2000a, DCOP 2008).

Washington, D.C., is divided into eight major political jurisdictions or wards of

[1] For the sake of being able to compare the 2008 data to the last available decennial census (2000), the estimates on race in this section are inclusive of those with both Hispanic and non-Hispanic ethnicity. Discussions of race and ethnicity in subsequent chapters of the assessment (particularly chapter 4) employ the current standard of comparing, among other groups, non-Hispanic white, non-Hispanic black, and Hispanic (of all races).

Table 1

Race/Ethnicity by Ward (2008)

		Race*				Ethnicity*
	Population	*Black*	*White*	*Asian/Pacific*	*Other***	*Hispanic*
Ward 1	77,392	51.8%	43.0%	4.8%	0.4%	24.8%
Ward 2	75,937	22.5%	68.8%	8.3%	0.4%	9.7%
Ward 3	77,888	6.2%	87.4%	6.2%	0.2%	6.3%
Ward 4	78,345	74.9%	23.4%	1.4%	0.3%	13.5%
Ward 5	72,116	89.8%	8.8%	1.0%	0.4%	2.8%
Ward 6	65,537	64.0%	33.4%	2.3%	0.3%	3.0%
Ward 7	72,912	97.8%	1.7%	0.2%	0.3%	1.1%
Ward 8	71,049	93.8%	5.5%	0.5%	0.2%	1.5%
Total	**591,176**	**61.8%**	**34.7%**	**3.1%**	**0.4%**	**8.1%**

The ward data were estimated using block group data provided by Caliper Corporation. As a result, the total population figures do not precisely match the U.S. Census Bureau data presented earlier.

*The block group data on race were not disaggregated by ethnicity; as a result, race data are inclusive of both Hispanic and non-Hispanic populations. The Hispanic ethnicity data are inclusive of all races.

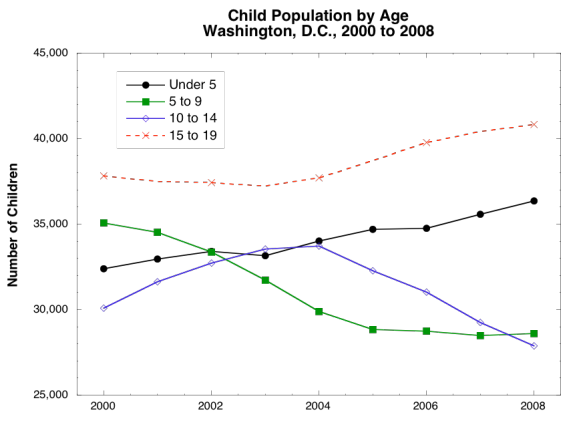
**The "other" race category includes Native Americans and those identifying as members of multiple races.

Source: D.C. Office of Planning, State Data Center (DCOP 2008).

fairly similar population size (figure 2). As depicted in table 1, with respect to race and ethnicity, the makeup of the populations within the wards varies greatly. According to the D.C. Office of Planning, in 2008, the latest year for which ward-level estimates are available, 60 percent of the population in wards 4, 6, 7 and 8 is black, while the same is true for whites in wards 2 and 3. Ward 2 has the highest percentage of Asians and Pacific Islanders (8.3), while Ward 1, easily the most heterogeneous of the District's wards, has the greatest percentage of Hispanics (24.8) (DCOP 2008).

The D.C. median age has remained very close to 35 years over the past several years (DCOP 2009). Despite this overall stability, there has been fluctuation in the relative size of the age cohorts for the district's children. Since 2000 there has been a decline in the population of children ages 5 to 9 (down 18.4 percent) and 10 to 14 (down 7.4 percent) (figure 3). However, over this same period the populations of children under age 5 and those ages 15 to 19 have seen increases over the same time period (12.2 percent and 8.0 percent, respectively).

Figure 3



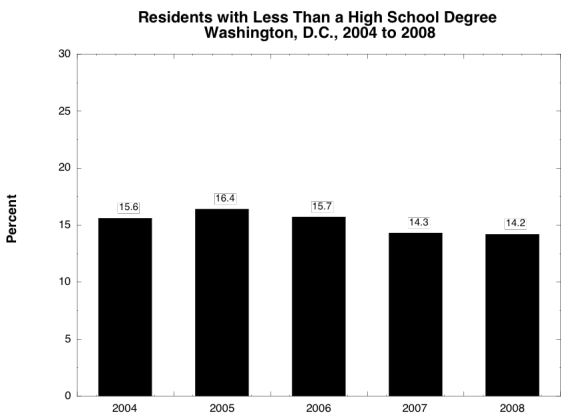
Source: D.C. Office of Planning 2009 (DCOP 2009).

The data suggest that over the next five years the District will graduate a minor baby boom to adulthood just as a new minor baby boom begins to move through the schools and other area social programs. If this is

the case (and migration into and out of the region does not become a major factor), the District should have a brief dip in its number of adolescents over the next 5 to 10 years, before the number of young adults (and the challenges associated with the teen years) begins to rise again.

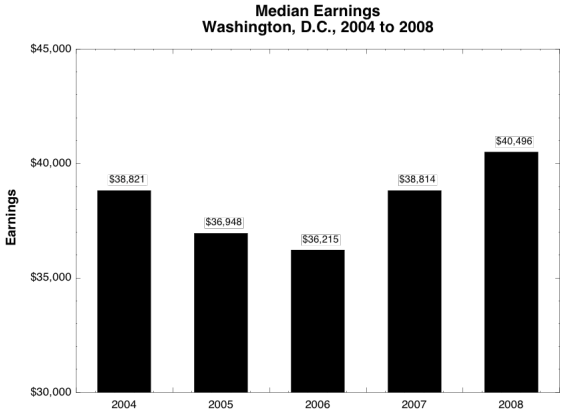
As with median age, educational attainment has remained fairly consistent for residents of the District in recent years. Though the percentage of residents with at least a high school degree has risen every year since 2005, the total increase over those three years has been moderate — just over 2 percentage points in total. As a result, the percentage of the District's population over age 25 without at least a high school diploma has also remained quite steady (figure 4). While the ideal is for everyone to earn a high school diploma, with only 14.2 percent of its residents over 25 years old not having a high school diploma in 2008, Washington, D.C. compares favorably to the nation (15.1 percent) as a whole (BC 2008a).

Figure 4



Source: U.S. Department of Commerce, Bureau of the Census 2004, 2005, 2006, 2007, 2008 (BC 2004a, 2005a, 2006a, 2007a, 2008a).

Figure 5



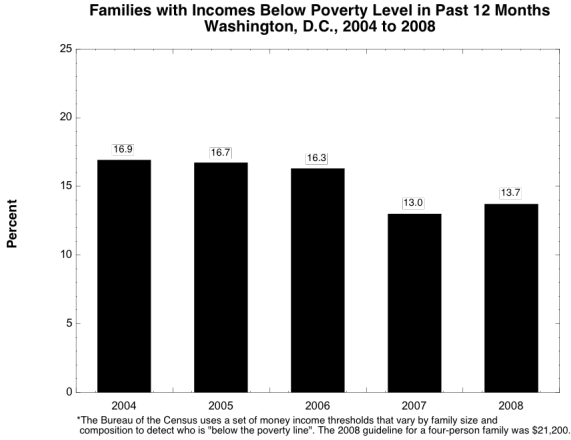
Source: U.S. Department of Commerce, Bureau of the Census 2004, 2005, 2006, 2007, 2008 (BC 2004b, 2005b, 2006b, 2007b, 2008b).

3.2. Economy.

To provide a general overview of economic conditions in Washington, D.C., we present data on median earnings, poverty, child poverty, unemployment, median home price, government assistance and crime. Overall, these economic indicators show a gradual improvement through 2007 followed by a downturn in 2008 and/or 2009 — the likely manifestation of a concurrent nationwide recession. The economic data also show stark disparities by ward, with wards 2 and 3 generally faring far better and wards 7 and 8 faring worse, economically, than the other wards in the District.

After dropping from $38,821 in 2004 to $36,215 in 2006, median earnings in Washington, D.C. rose to $40,496 in 2008 (figure 5). The measures of family

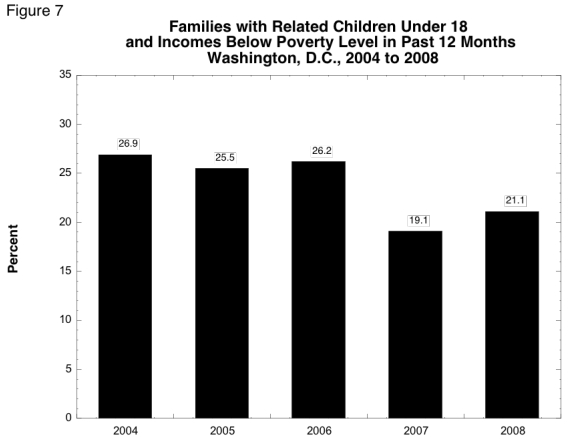
Figure 6



*The Bureau of the Census uses a set of money income thresholds that vary by family size and composition to detect who is "below the poverty line". The 2008 guideline for a four-person family was $21,200.

Source: U.S. Department of Commerce, Bureau of the Census 2004, 2005, 2006, 2007, 2008 (BC 2004b, 2005b, 2006b, 2007b, 2008b).

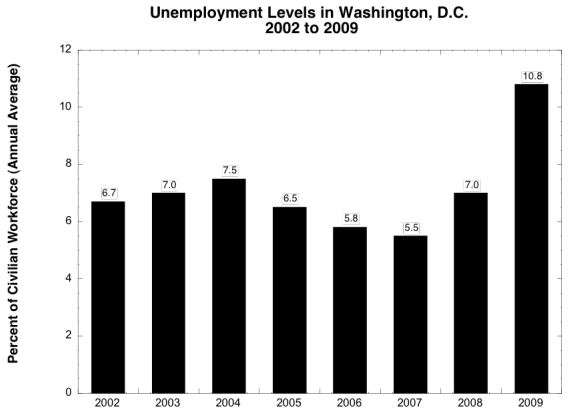
Figure 7



*The Bureau of the Census uses a set of money income thresholds that vary by family size and composition to detect who is "below the poverty line". The 2008 guideline for a four-person family was $21,200.

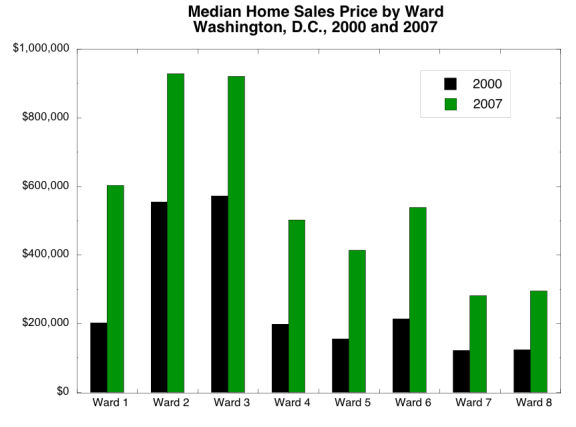
Source: U.S. Department of Commerce, Bureau of the Census 2004, 2005, 2006, 2007, 2008 (BC 2004b, 2005b, 2006b, 2007b, 2008b).

Figure 8



Source: U.S. Department of Labor, Bureau of Labor Statistics 2010 (BLS 2010).

Figure 9



Source: www.NeighborhoodinfoDC.org 2009 (NIDC 2009a).

poverty over the past 12 months tell a similar story. As shown in figure 6, family poverty dropped from 16.9 percent in 2004 to 13.0 percent in 2007 before slightly ticking upward to 13.7 percent in 2008. The pattern for general family poverty was matched by the trends for families with children. As can be seen in figure 7, the percentage of families with related children under 18 and incomes below the poverty level declined from 26.9 percent in 2004 to 19.1 percent in 2007 before moving up to 21.1 percent in 2008.

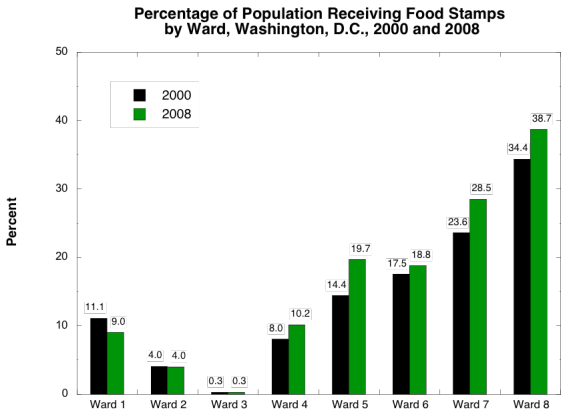
Not surprisingly given the previous data, D.C.'s unemployment numbers declined over the same period, falling from an annual average of 7.5 percent in 2004 to 5.5 percent in 2007 before climbing back to 7.0 percent in 2008 (figure 8). As was suggested above, the well-documented economic woes throughout the United States and the world that began in 2008 and continue through the present almost certainly had a negative impact on the District's employment measures. Recent data from the U.S. Bureau of Labor Statistics show that the unemployment rate in D.C. had increased to an unprecedented 12.1 percent by December 2009 (BLS 2010).

Reflecting upon these figures, V. Dion Haynes of the *Washington Post* recently noted that "[t]he District's 12.1 percent jobless rate is the highest since the government began collecting the data in 1976" (WP 2010b). In an article four days earlier, Haynes had noted that unemployment in D.C. is highest among the city's black residents, "whose [unemployment] rate is three times the level of whites" (i.e., 18.9 percent for blacks and 6.1 percent for whites, according to the Economic Policy Institute) (WP 2010a).

Evidence of these racial disparities can also be observed geographically in comparisons of D.C.'s eight wards. In

virtually all economic measures, wards 7 and 8, the two wards that sit to the east of the Anacostia River whose populations are overwhelmingly black, rank at the bottom, while wards 2 and 3, both located primarily in northwest D.C. and whose populations are mostly white, are the most prosperous. This is true whether one looks at median home sales price (figure 9), persons receiving services under the Supplemental Nutrition Assistance Program, i.e., "food stamps" (figure 10) or individuals receiving Temporary Assistance for Needy Families (TANF) (figure 11).

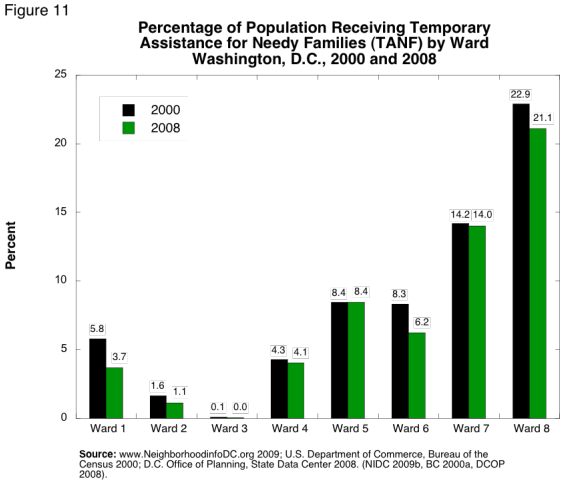
Figure 10



The median home sales price in Ward 2 in 2007 was $928,000, followed closely by Ward 3's median price of $920,000. These figures are more than three times the median home sales prices found in wards 7 and 8, which were $281,000 and $295,000, respectively. However, it was not just wards 2 and 3 that experienced sharp increases over their 2000 level (e.g., median home sale prices in wards 7 and 8 were both more than 100 percent higher in 2007 than they were in 2000). While the Washington D.C. region has not seen quite as sharp a drop in home values as other areas in the United States, it remains to be seen if the value of homes will stay at or the near the levels observed in 2007.

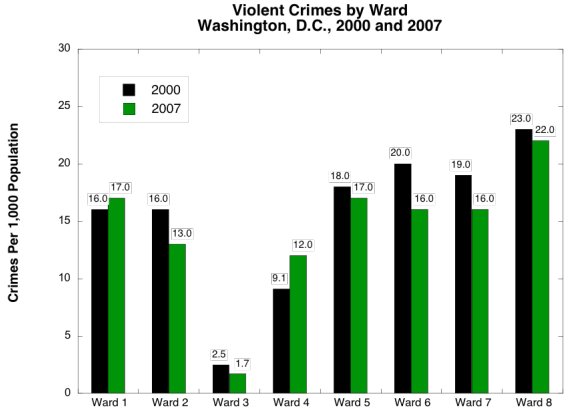
With 38.7 percent of its residents receiving food stamps in 2008, Ward 8 residents were more than 126 times more likely to use this assistance than those living in Ward 3 (0.3 percent). Families receiving food stamps was also one of the few economic measures where District residents appear to fare worse in 2008 than they had in 2000, though these figures may be misleading as changes eligibility criteria over this period may also explain the increase. The disparities by ward, especially between wards 8 and 3, can also be observed in the distribution of TANF. In Ward 8, 21.1 percent of residents received this aid, as compared to 0.04 percent in Ward 3 (34 residents total).

Figure 11



Although not an economic measure *per se*, many people associate crime with poverty. Yet when looking at the violent crime numbers in D.C. (figure 12), the trends consistently seen with respect to the previous economic measures by ward do not translate exactly. While a higher rate of violent crimes was reported in Ward 8 (22 crimes per 1,000 residents) in 2007 than was the case in other wards of the District, Ward 7 has seen recent improvement, and its 2007 rate of 16 crimes per 1,000 is tied for fourth lowest of the 8 wards. Ward 3 was by far the safest ward by this particular measure (1.7 crimes per 1,000), but it was Ward 4, not well-to-do Ward 2, that had the

Figure 12



second-lowest rate of violent crime (12 crimes per 1,000) in 2007.

In a city as diverse as Washington, it is not surprising to find, as is the case in many urban areas, great affluence contiguous with areas of high crime and poverty. The key to maximizing Title V resources rests in understanding which areas are most in need of which services and resources, and making appropriate decisions based on this understanding.

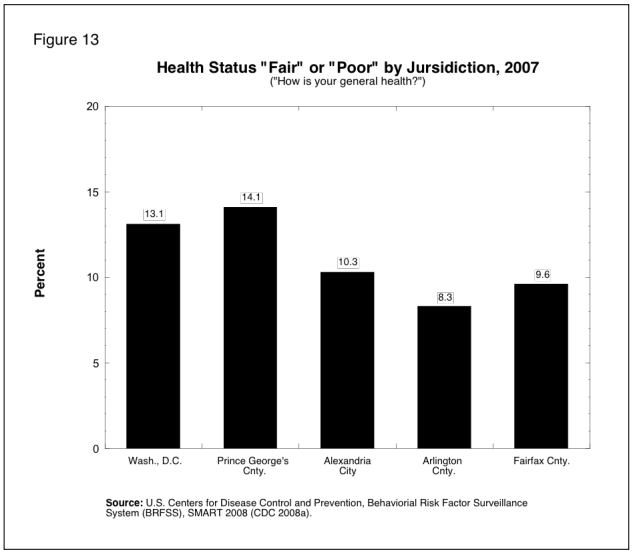
3.3. Health.

Before examining the Title V health indicators, it will be helpful to gain a better perspective of the overall state of health for all residents of the District of Columbia. For this reason it was decided to compare the District to a few of its closest neighbors in several important general health indicators using the U.S. Centers for Disease Control and Prevention's (CDC) Selected Metropolitan/Micropolitan Area Risk Trends (SMART) from the Behavioral Risk Factor Surveillance System (SMART BRFSS).

We employed both cross-sectional and longitudinal comparisons to get the most comprehensive perspective of the District's health data. Prince George's (Maryland), Fairfax (Virginia), and Arlington (Virginia) counties and the City of Alexandria (Virginia) were selected for cross-sectional analysis due to their proximity to the District and the availability of consistent federally collected data (CDC 2008a-q). In addition to reviewing changes in the District's health overtime, longitudinal data for Prince George's County were also analyzed to see how the trends in this inner-suburban county compared to those in Washington, D.C. Prince George's County was selected for this further comparison because, of the areas included in the cross-sectional analyses, its demography most closely mirrored that of the District.

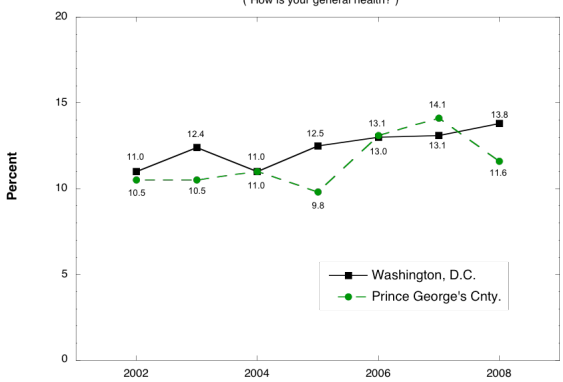
The District and Prince George's County have comparable racial/ethnic demographics. Prince George's County actually has a higher percentage (63.9 percent) of black residents than does D.C. (53.4 percent); none of the other jurisdictions included in the cross-sectional analyses has even half the percentage of African-Americans as does the nation's capital (BC 2008a). Furthermore, Prince George's County and Washington, D.C., are quite similar in several other aspects, including median age (34.9 years in D.C. as compared to 35.5 years in Prince George's), average family size (3.31 members in D.C. as compared to 3.29 in Prince George's) and educational attainment. (In D.C., 85.8 percent of the population age 25 and over has a high

Figure 13



school degree or higher; in Prince George's County the figure is 85.5 percent.) One big difference that should be noted between the two areas, however, is that Prince George's County residents have a much higher median household income ($72,166) than do Washington, D.C., residents ($57,936) (BC 2008b).

Figure 14

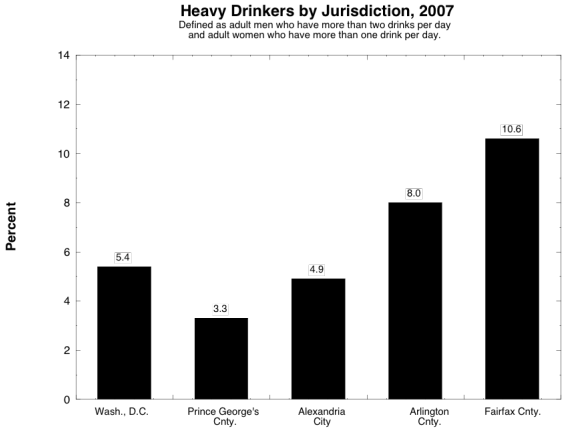


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, SMART 2008 (CDC 2008a).

Using both methods (i.e., cross-sectional and longitudinal), we assessed measures of overall health, alcohol consumption, tobacco use, asthma, heart disease, exercise, nutrition, and diabetes. (Test of significance, odds ratios and 95-percent confidence intervals for this section are presented in tables 17 and 18, which are located in appendix D.) We find that, while the District does not compare favorably to all of its neighbors in the area of self-reported health, drinking, heart attacks, and staying physically active, on many of the other measures the District appears to be faring as well as its wealthier, suburban neighbors. On most of these measures the Washington, D.C. has not changed significantly since 2002. However, there has been a significant decrease in self-reported smoking and a significant increase in self-assessments of only "fair" or "poor" overall health status during this period.

Overall health status was the first indicator examined in this inter-jurisdictional comparison; data for this indicator were gathered from the CDC's National Center for Chronic Disease Prevention and Health Promotion. To evaluate health-related quality of life, the CDC uses a set of measures called the "Healthy Days Measures." As a part of this study, respondents throughout the Washington, D.C. region were asked rate their health status. As shown in figure 13 and table 17, respondents from the District (13.1 percent) were significantly more likely than those from Arlington County (8.3 percent) to report their health as "fair" or "poor" in 2007. While more survey respondents gave their health low ratings in Prince George's County (14.1 percent) than in Washington, D.C. in 2007, neither this difference nor those between the District and the City of Alexandria (10.3 percent) or D.C. and Fairfax County (9.6 percent) were statistically significant.

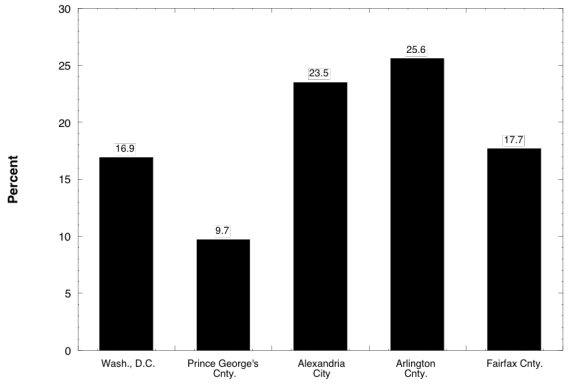
Figure 15



Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008d).

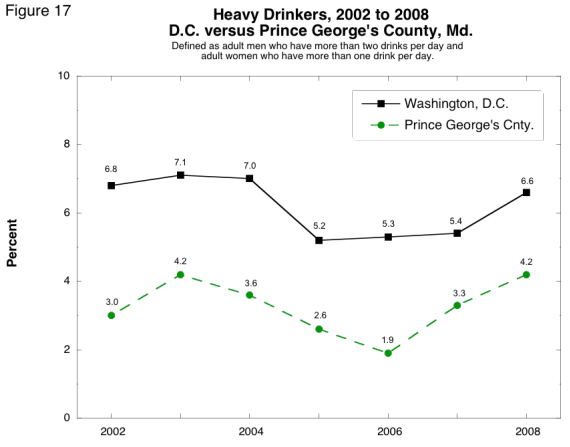
When observing the trends over time, it becomes apparent that the lack of statistical difference between Washington, D.C. and Prince George's County on self-assessed health status reflects a genuine lack of difference between the two jurisdictions. Between 2002 and 2008, there is not a single year where there is a significant difference between the two jurisdictions, and each was higher than the other for at least twice over this period.

Figure 16



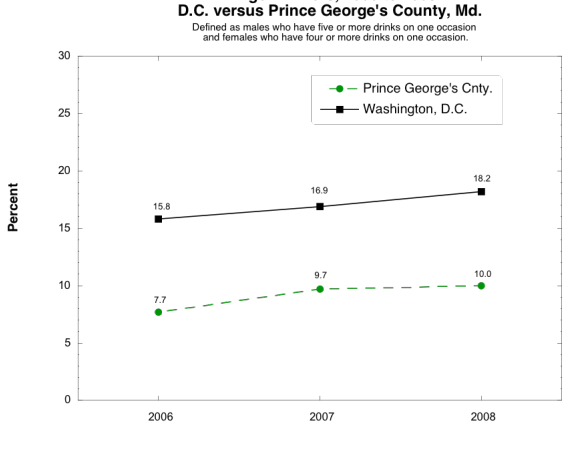
Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008c).

Figure 17



Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008d).

Figure 18



Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008c).

Alcohol consumption was another indicator used to assess the health of the District's residents compared to that of their suburban neighbors. Excessive alcohol consumption can lead to a variety of health and societal problems such as liver disease, cancer, high blood pressure, psychological disorders, unintentional injuries, violence, fetal alcohol disorders, and even sudden infant death syndrome (SIDS). To evaluate alcohol consumption, we used questions from the SMART survey concerning heavy (figures 15 and 17) and binge (figures 16 and 18) drinkers (CDC 2008c-d).

Respondents from Washington (5.4 percent) were significantly more likely (table 17) than those from Prince George's County (3.3 percent) to report being heavy drinkers (defined as men who have more than two drinks per day and women who have more than one drink per day) in 2007. On the other hand, respondents from Fairfax County (10.6 percent) were significantly more likely to report being heavy drinkers. There were no significant differences in the responses of District residents to those of Arlington County (8.0 percent) and Alexandria (4.9 percent).

With respect to binge drinking (defined as males who have five or more drinks on one occasion and females who have four or more drinks on one occasion), once again respondents from the District (16.9 percent) were significantly (table 17) more likely to report this behavior in 2007 than those from Prince George's County (9.7 percent). Residents of Arlington County (25.6 percent) were significantly more likely to report binge drinking than those of Washington, while the differences between the District and Fairfax County (17.7 percent) and Alexandria (23.5 percent).

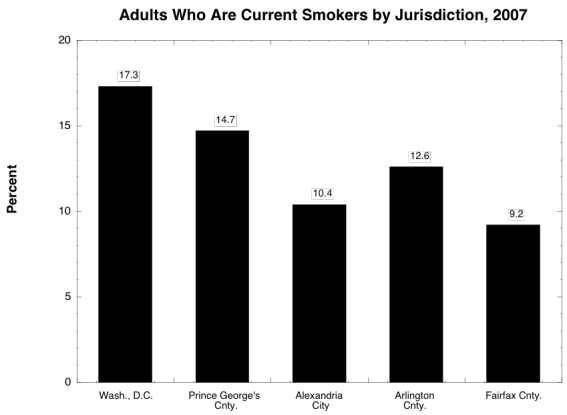
Although the statistics for alcohol consumption are largely positive when comparing D.C. to the overall

surrounding area, the District has significantly lagged behind Prince George's County on both measures (figures 17 and 18, and table 18) since at least 2002. Between 2002 and 2008, Washington always had more residents report being heavy drinkers than did Prince George's County; and most years the difference between the two jurisdictions were significant. For each of the years that binge drinking was assessed (2006 to 2008), District residents were significantly more likely to report binge drinking. Though it should be noted that Prince George's County's numbers are among the best in the region for both measures, and there has not been a significant increase in the number of heavy or binge drinkers over the period assessed.

Another serious health hazard for a wide variety of ailments, both to oneself and to those nearby, is smoking. And on this measure the District has not performed very well. As seen in figure 19, in 2007 no jurisdiction reported a higher percentage of adults who are current smokers than Washington, D.C. (17.3), though none of the differences were statistically significant (table 17). When compared, longitudinally, to Prince George's County, the District appears to have performed more poorly (figure 20), though, between 2002 and 2008, 2003 was the only year that significantly more District residents reported smoking than did residents of Prince George's County (table 18). On the bright side, however, the District's smoking rate declined significantly, falling 33.3 percent since 2003, so it appears that progress is being made in this area (CDC 2008a).

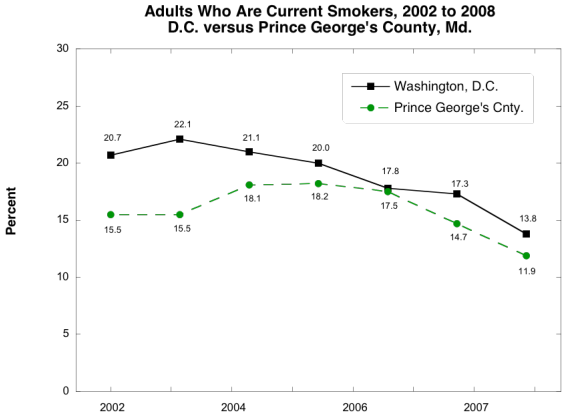
Perhaps a bit surprisingly, given their urban setting, District residents (9.2 percent) were not significantly more likely to report currently having asthma than their counterparts from Prince George's (7.8 percent), Arlington (9.2 percent) and Fairfax (8.4 percent)

Figure 19



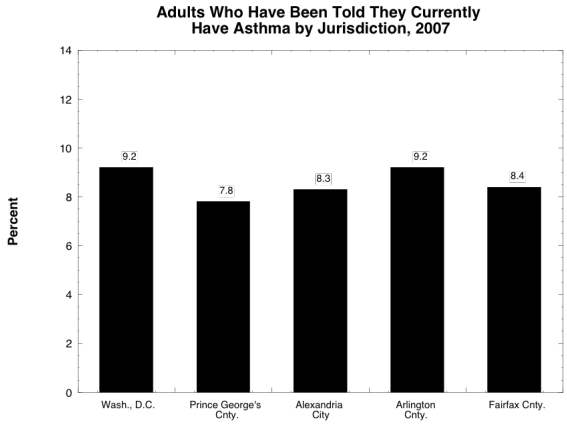
Source: U.S. Centers for Disease Control and Prevention, Behavioral Risk Factory Surveillance System (BRFSS), SMART 2008 (CDC 2008e).

Figure 20



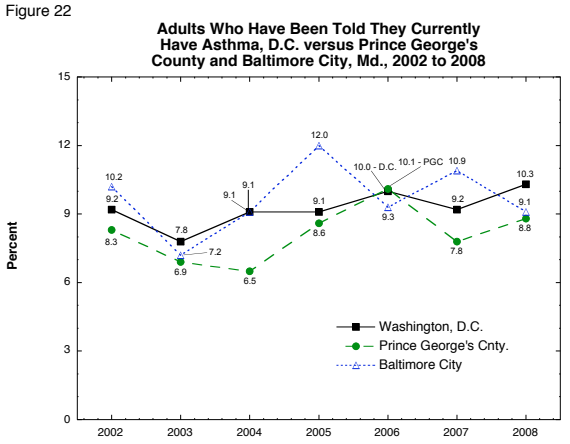
Source: U.S. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008e).

Figure 21



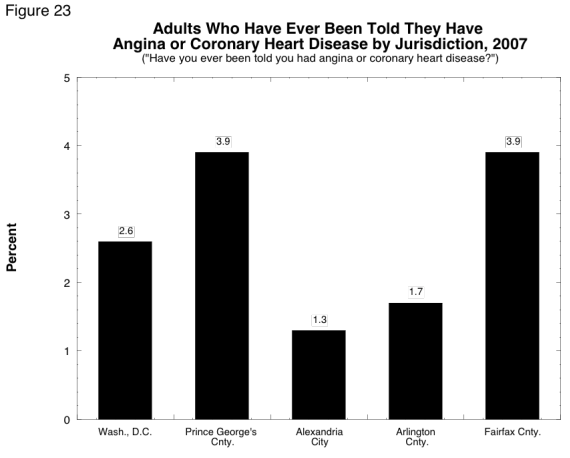
Source: U.S. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008f).

Figure 22



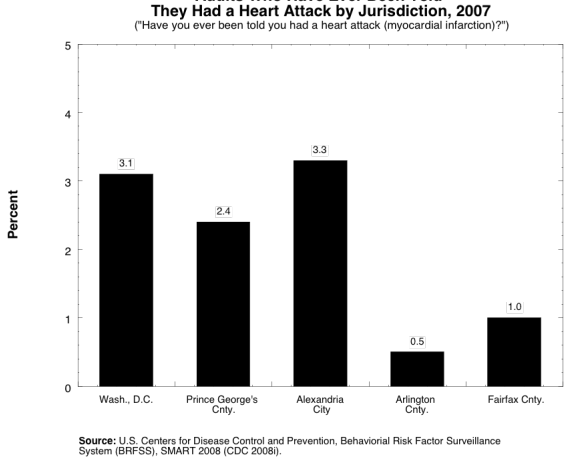
Source: U.S. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008g).

Figure 23



Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008h).

Figure 24



Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008i).

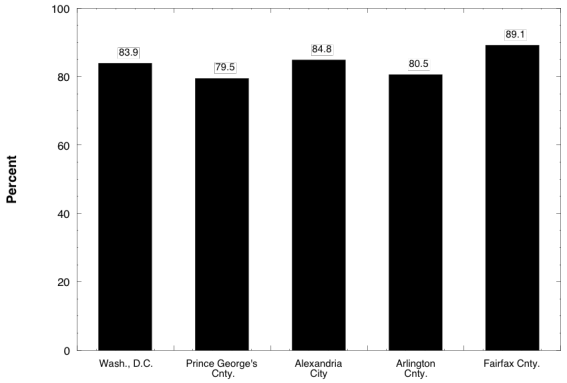
counties or those from Alexandria (8.3 percent) (figure 21 and table 17). Likewise there were no significant differences between Washington, D.C., Prince George's County and nearby Baltimore, Maryland, between 2002 and 2008 (figure 22 and table 18). Furthermore, while a higher percentage of District residents reported current asthma in 2008 (10.3 percent) than did in 2002 (9.2 percent), the difference was not significant (table 18) (CDC 2008e-f).

The District is in the middle of the pack when compared to the surrounding region for most heart-disease-related measures included in the CDC's SMART survey. D.C. reported the median percentage (of the five jurisdictions being compared) in 2007 (2.6 percent) for adults who have ever been told they have angina or heart disease (figure 23); the differences between the District and Prince George's (3.9 percent), Arlington (1.7 percent) and Fairfax (3.9 percent) counties and Alexandria (1.3 percent) were not significant (table 17) (CDC 2008h). (Longitudinal data were not available for the heart-related measures included in this assessment.) As shown in figure 24, District residents (3.1 percent) were among those most likely in the region to report being told they had a heart attack (CDC 2008i). District residents were significantly more (table 17) likely to report a heart attack than residents of Arlington (0.5 percent) and Fairfax (1.0 percent) counties. Only Alexandria (3.3 percent) had a higher percentage of residents reporting a heart attack, though the difference from the District's percentage was not significant (as was also the case with Prince George's County residents [2.4 percent]).[2]

[2] The CDC defines having a history of heart attack as persons saying "yes" to the question, "Have you EVER been told by a doctor or other health professional that you had a heart attack (also called myocardial infarction)?" (CDC 2008i)

One of the best ways to proactively avoid heart disease is to stay on top of your condition by having your blood cholesterol checked. On this important measure the District again performed about average for the region in 2007, with 83.9 percent of adults reporting they had had their blood cholesterol checked within the last 5 years (figure 25). There were no significant differences (table 17) between the responses of District residents and those of Prince George's (79.5 percent), Arlington (80.5 percent) and Fairfax (89.1 percent) counties or Alexandria (84.8 percent) (CDC 2008j).

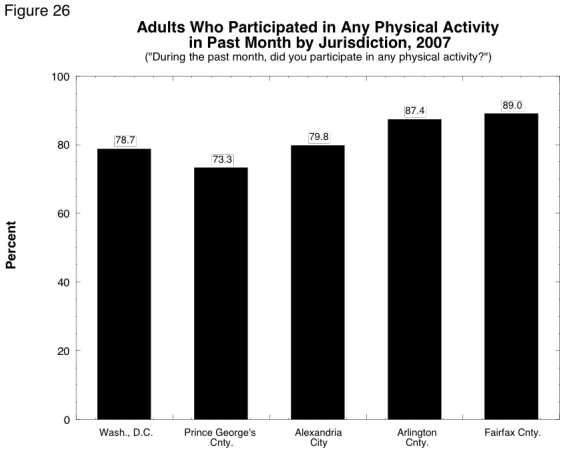
Figure 25



Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008j).

Two other key preventive health measures for avoiding heart disease and a wide variety of other health problems are exercising and eating a diet rich in fruits and vegetables. When looking at adults who reported participating in any physical activities in the past month in 2007 (figure 26), residents of Washington, D.C., at 78.7 percent, were significantly (table 17) more likely to report physical activity than those of Prince George's County (73.3 percent). However, District residents were significantly less likely to report physical activity than the residents of Arlington (87.4 percent) or Fairfax (89.0 percent) counties. There was no significant difference between the responses of District residents and those from Alexandria (79.8 percent) (CDC 2008k).

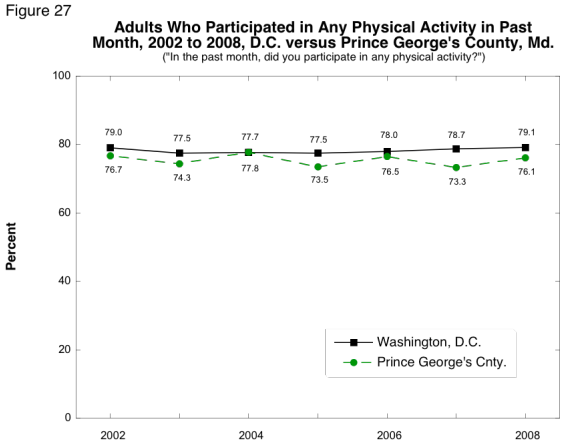
Figure 26



Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008k).

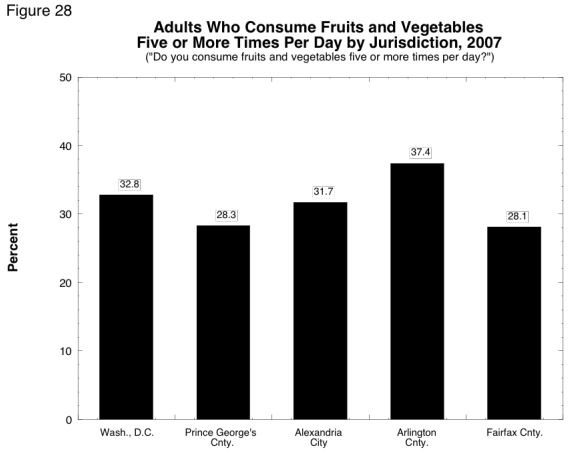
Physical activity was one of the more stable measures for the District. Not only was 2007 the only year between 2002 and 2008 that Washington, D.C. residents had responses that were significantly different than those of Prince George's County (figure 27 and table 18), the percentage of District residents reporting that they did the recommended amount of physical activity (over the month prior to the survey) in 2008 (79.1 percent) was nearly unchanged from the percentage in 2002 (79.0 percent) (CDC 2008l).

Figure 27



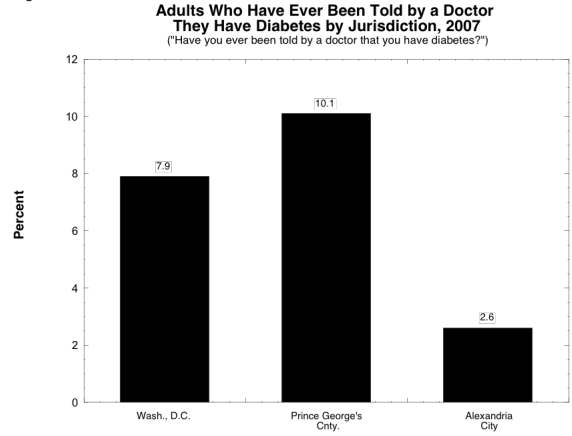
Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008l).

Figure 28



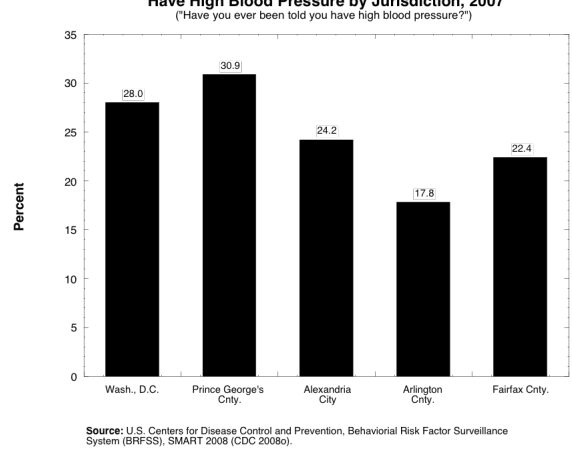
Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008m).

Figure 29



Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008n).

Figure 30



Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008o).

The CDC monitors the percentage of residents who eat five or more servings of fruits and vegetables per day for several reasons: 1) a diet high in fruits and vegetables is associated with a decreased risk of chronic diseases; 2) a reduced-calorie diet can be beneficial to weight management; and 3) Healthy People 2010 health objectives include increasing to 75.0 percent the percentage of persons over age 2 who eat at least 2 daily servings of fruit and 3 daily servings of vegetables (CDC 2007e).[3] As depicted in figure 28, on this measure, there were no significant differences (table 17) between the response of District residents (32.8 percent getting the recommended servings) and that of residents of Alexandria (31.7 percent), or those of Prince George's (28.3 percent), Arlington (37.4 percent) and Fairfax (28.1 percent) counties in 2007 (CDC 2008m).

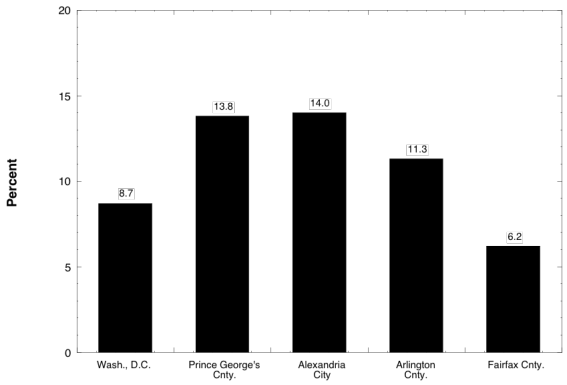
Closely correlated with heart disease is diabetes; however, it is difficult to draw many conclusions from the limited data available for this indicator. Encouragingly, as seen in figure 29, in 2007 fewer District residents reported ever having been told by a doctor they had diabetes (7.9 percent) than did residents of Prince George's County (10.1 percent); however, the difference between the two jurisdictions was not significant (table 17). There was a significant difference between the percentage of Alexandria (the only other jurisdiction in our comparison group for which data are available on this question) residents reporting diabetes (2.6 percent) and that of District residents (CDC 2008n).

Another key health indicator related to heart disease is high blood pressure

[3] Healthy People 2010 is a set of health objectives developed by leading federal agencies for the nation to achieve over the first decade of the century.

(figure 30). Washington, D.C. residents (28.0 percent) were significantly (table 17) more likely to report being told they had high blood pressure than were residents of Fairfax County (17.8 percent). Only Prince George's County (30.9 percent) reported a higher percentage of adults who had been told they had high blood pressure in 2007 than did the District, but this difference was not significant nor were the percentages reported from Alexandria (24.2 percent) and Arlington County (22.4 percent) (CDC 2008o).

Figure 31



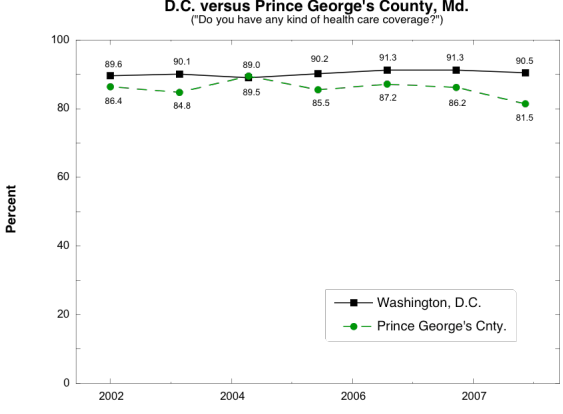
Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008p).

The final general health indicator reviewed in this section deals with residents' ability to pay for their health care. With 8.7 percent of its residents reporting not having health care coverage (CDC 2008p), the only jurisdiction reporting better coverage than the District in 2007 was Fairfax County (6.2 percent) (figure 31). Fewer District residents reported not having health coverage than did residents of Alexandria (14.0 percent), and Prince George's (13.8 percent) and Arlington (11.3 percent) counties — in the case of Prince George's County, the difference was significant (table 17; note: significance is a function of both the magnitude of the difference and sample size).

When compared to Prince George's County between 2002 and 2008, the District's numbers look even stronger, consistently outperforming its neighbor, and with the difference appearing to be getting more pronounced (figure 32); 2004 was the only year when there was not significantly more health coverage reported in the District than in Prince George's County (table 18). There were no significant changes in the reported level of health coverage in the District during this period (CDC 2008q).

Though there are obviously areas for improvement to be found in the health measures inspected, on the whole the District appears to be faring adequately with regard to its overall general health when compared to its neighbors, especially when one considers the District's urban environment, an environment often associated with poorer health outcomes than suburban areas. Areas of particular strength for the nation's capital when compared to its neighbors include blood cholesterol monitoring, participation in physical activity, consumption of fruits and vegetables, and health care coverage.

Figure 32



Source: U.S. Centers for Disease Control and Prevention, Behaviorial Risk Factor Surveillance System (BRFSS), SMART 2008 (CDC 2008q).

3.4. Conclusion.

Any useful assessment of Washington, D.C.'s needs must be sensitive to its diversity; different areas of the District have unique challenges and solutions. A

program suited for one of the District's wards may be wholly ineffective in another. Furthermore, the design of these programs should be based in evidence, not stereotype or conjecture. As the data on crime rates in the wards and the reported health of Washington D.C. residents as compared to that of the surrounding, wealthier jurisdictions show, beliefs can sometimes be misleading. It is with these considerations in mind that we turn, in the next chapter, to the child well-being indicators to provide information that will guide the District's Title V program through the first half of the next decade.

4. Title V Indicators.

4.1. Introduction.

The D.C. Department of Health, in cooperation with InterGroup Services, developed a series of indicators and corresponding measures to assess the health needs of the Title V population in the District of Columbia. Several of the indicators were selected to review the status of the nine community-level priorities that were chosen as a result of the 2005 Title V needs assessment. The 2005 Washington, D.C., priorities were:

- Improve oral health among children, youth and pregnant women.
- Reduce unintended pregnancies and teen births.
- Enhance nutrition and increase physical activity for children and youth.
- Decrease violence toward and by children and youth.
- Increase access to medical homes for CSHCN and support seamless systems of care.
- Provide STD (sexually transmitted disease) screening and prevention services for teens.
- Decrease infant mortality.
- Improve school-based asthma management programs.
- Decrease lead poisoning for children less than six years of age.

Additional indicators dealing with the availability of licensed child care in the District and overall access to health care were added to address feedback gathered in the focus groups and key informant interviews that were conducted for this year's assessment.

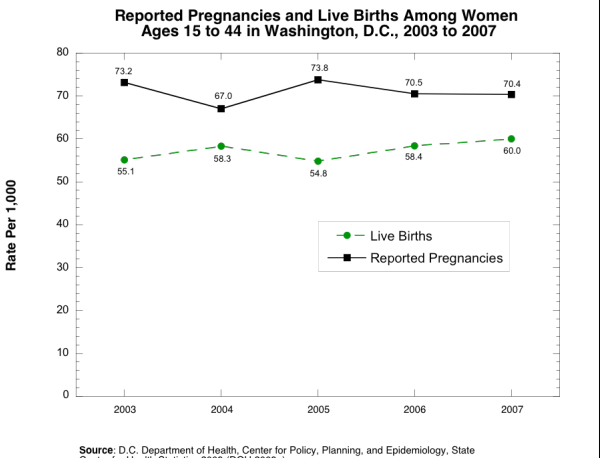
All indicators selected for this section have been examined as they relate to the overall health status of the three MCH population groups:

- Pregnant women, mothers and infants.
- Children.
- Children with special health care needs (CSHCN).

4.2. Pregnant Women, Mothers and Infants.

The Title V legislation directs states to identify needs for preventive and primary care services for all the populations served by Title V. Among the needs identified in the most recent assessment for pregnant women, mothers and infants was to decrease the number of unintended pregnancies and teen births.

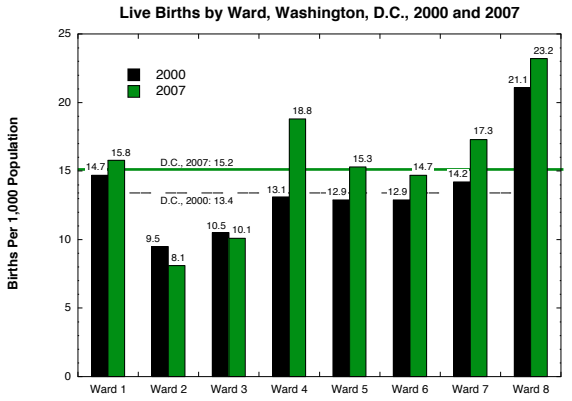
Figure 33



4.2.1. Births.

According to the Department of Health, live births in the District rose from 2005 to 2007, going from 54.8 live births per 1,000 women in 2005 to 60.0 in 2007 (figure 33) (DOH 2009a: table 1). The

Figure 34



Source: D.C. Department of Health, Center for Policy, Planning, and Epidemiology, State Center for Health Statistics 2010 (DOH 2010a).

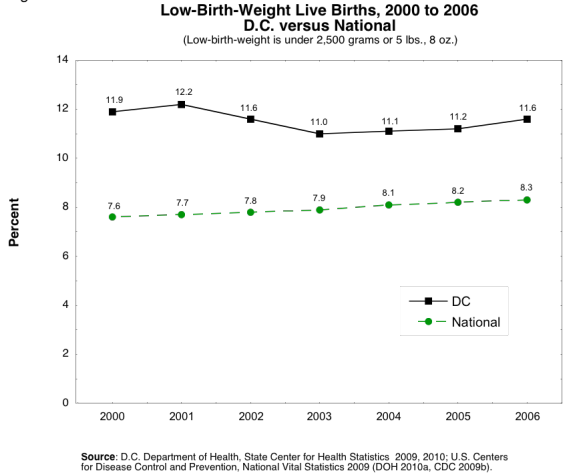
District-wide increase in live births happened while a simultaneous decrease in the pregnancy rate for women ages 15 to 44 was occurring. In 2005, the start of the live-birth surge, the District's pregnancy rate was 73.8 per 1,000 women, but by 2007 that rate had dropped to 70.4. While the manner in which abortions are recorded in Washington, D.C. makes it impossible to draw firm conclusions, the data on pregnancies and live births suggest that, overall, there was a drop in unwanted pregnancies between 2005 and 2007.[4]

Data by race show that in 2007, 55.3 percent of reported pregnancies to women were among black women, while 26.1 percent were among whites, 2.8 percent were Asian/Pacific Islander, and 15.1 percent were other races; 15.7 percent were of Hispanic ethnicity (DOH 2009a: table 3). According to the same source, 56.0 percent of D.C. women who gave birth in 2007 were black, 26.7 percent were white, 2.4 percent were Asian/Pacific Islander, and 15.0 percent were other races; 16.8 percent were of Hispanic ethnicity.

Using a rate based on the total population (as contrasted to the rate of live births per 1,000 women age 15 to 44 found in figure 33), figure 34 shows that the District-wide increase in live births from 2000 (13.4 live births per 1,000 total population) to 2007 (15.2 per 1,000) was mirrored in most wards.[5] Wards 2 (9.5 to 8.1 per 1,000) and 3 (10.5 to 10.1 per 1,000) were the only wards to record a decline in the rate of live births over this period. The largest increase occurred in Ward 4 (13.1 to 18.8 per 1,000), and Ward 8 reported the highest rate of live births in both 2000 (21.1 per 1,000) and 2007 (23.2 per 1,000) (DOH 2010a).

When live births are on the rise, as they were in the District for the latest two years of data, an increase in low-birth-weight live births might be expected as well. However, after increasing from 11.2 percent in 2005 to 11.6 percent in 2006 (figure 35), low-birth weight live births actually decreased below 2005's level in 2007 (11.1 percent) (DOH 2009b, 2010a). This is a possible indication that improvement was witnessed in prenatal care in the District

Figure 35



Source: D.C. Department of Health, State Center for Health Statistics 2009, 2010; U.S. Centers for Disease Control and Prevention, National Vital Statistics 2009 (DOH 2010a, CDC 2009b).

[4] Pregnancy rates are inclusive of pregnancies that result in live births, legally induced abortions and fetal death. However, abortion reporting in D.C. is voluntary, and the Department of Health does not receive reports regarding abortions performed in private physicians' offices (DOH 2009).

[5] The figure 33 rate is preferable; however, only the rates per the entire population were available for the wards.

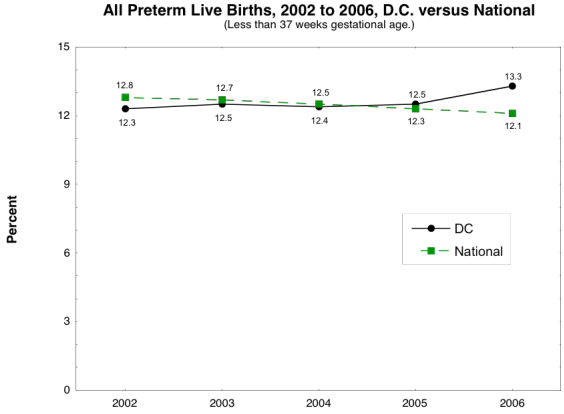
over this period (NCHS 2010: p. 168, table 8).

When examining preterm births (figure 36), again an increase was seen from 2005 to 2006, as would be fair to expect during an increase in live births, though the increase in preterm births (6.4 percent increase) outpaced the increase in overall births (2.7 percent) seen over the same period. Furthermore, the rate of preterm births was trending upward in Washington, D.C. between 2002 and 2006, while the rate of preterm births in the entire U.S. trended downward over this same period (CDC 2009c; DOH 2008i, 2010a). Unfortunately, at the time of publication, data were not available for 2007, which would have allowed us to learn whether preterm births continued to rise along with the live birth rate, or whether, as with the numbers for low- and very-low-birth-weight live births, the District was able to level out or even decrease the percent of preterm births.

Looking at low-birth-weight live births by ward (figure 37), Ward 8 was home to the District's highest percentage of low-birth-weight babies (14.2 percent) in 2007, followed by wards 7 and 5 (13.8 and 12.8 percent, respectively). Wards 2 and 3 had the District's lowest percentages, at 7.1 and 7.2 percent, respectively. Wards 4 and 6 were the only two wards to have witnessed an increase in low-birth-weight live births between 2000 and 2007 (DOH 2010a).

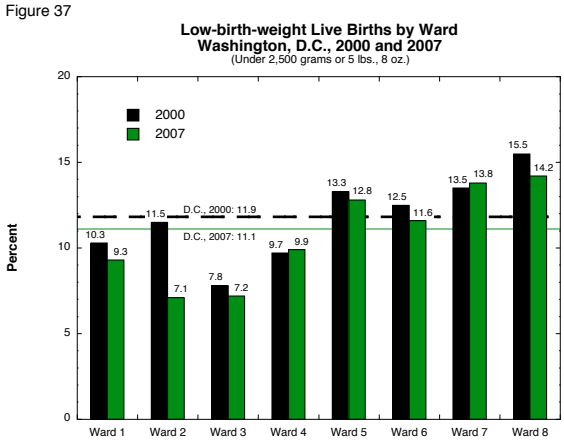
In summary, there is evidence, albeit limited, that the number of unwanted pregnancies, a priority from the 2005 needs-assessment process, is declining. While the rate of low-birth-weight live births in the District is higher than it is in the rest of the nation, there has been improvement since 2000. The rate of preterm births, which has increased and surpassed that of the nation over the last

Figure 36



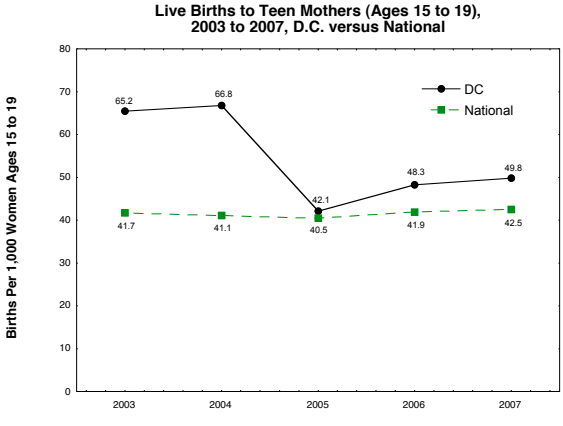
Source: D.C. Department of Health, Center or Policy, Planning, and Epidemiology, State Center for Health Statistics 2008, 2010; U.S. Centers for Disease Control and Prevention, National Vital Statistics 2009 (DOH 2008i, DOH 2010a, CDC 2009c).

Figure 37



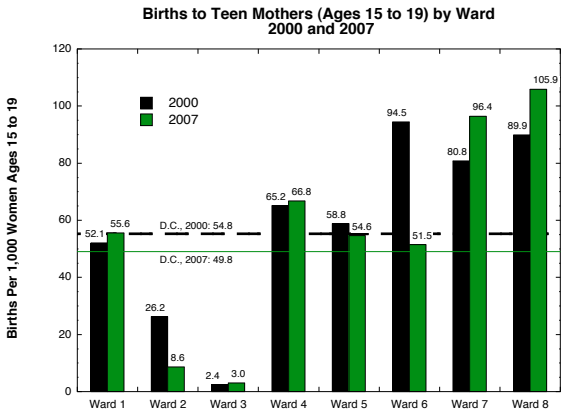
Source: D.C. Department of Health, Center for Policy, Planning, and Epidemiology, State Center for Health Statistics 2008 (DOH 2010a).

Figure 38



Source: D.C. Department of Health, Center for Policy, Planning, and Epidemiology, State Center for Health Statistics 2009; U.S. Centers for Disease Control and Prevention, Vital Statistics (DOH 2009a, CDC 2009c).

Figure 39



Source: D.C. Department of Health, Center for Policy, Planning, and Epidemiology, State Center for Health Statistics 2010 (DOH 2010a).

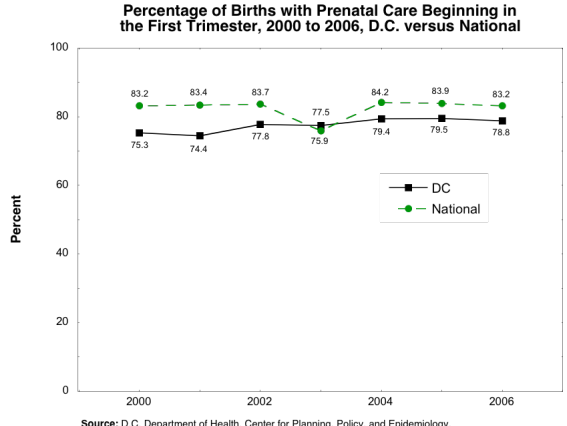
five years surveyed, is a clear area of concern for Washington, D.C.

4.2.2. Teen Pregnancy.

Reducing the number of unintended pregnancies and teen births is a Title V priority for the District, and the D.C. Department of Health's research shows that from 2003 to 2007, the number of live births per 1,000 women ages 15 to 19 did in fact drop from 65.2 to 49.8 per 1,000 (figure 38) (CDC 2009a, DOH 2009a). However, the 2007 number actually represents a second consecutive increase in the rate since its low in 2005, when the figure had dropped to 42.1 per 1,000. The post-2005 rates are less remarkable when compared to the average rate between 2000 and 2002 of 50.4 per 1,000 (DOH 2010a), suggesting that 2003 and 2004 rates were unusually high for the District. When compared to the U.S. (CDC 2009c: p. 11, table 5), 2005 was the only year during this period when the rate of teen pregnancy in Washington, D.C., was not substantially higher than the rate in the rest of the country (42.1 compared to 40.5 per 1,000).

When examining teen births by ward (figure 39), it is apparent that the decrease in the rate of teen births between 2000 and 2007 (from 54.8 to 49.8 per 1,000) was not a District-wide phenomenon (DOH 2010a). Of the eight wards, only three — wards 2, 5 and 6 — experienced drops in the rate of births to teen mothers over that time. Ward 6 nearly halved its rate, moving from the ward with the highest rate in 2000 (94.5 per 1,000) to ward with the third lowest rate in 2007 (51.1 per 1,000). The already low (relative to the other wards of Washington, D.C.) rate of teen births in Ward 2 dropped by more than two thirds from 26.2 to 8.6 per 1,000 between 2000 and 2007. Over this same period teen births increased in Ward 1 (52.1 to 55.6 per 1,000), Ward 3 (2.4 to 3.0 per 1,000), Ward 4 (65.2 to 66.8 per 1,000), Ward 7 (80.8 to 96.4 per 1,000) and Ward 8 (89.9 to 105.9 per 1,000). Overall, the District has been successful in its efforts to reduce teen births, especially in wards 2 and 6. However, this area remains a major concern that disproportionately affects Washington, D.C., as compared to the rest of the nation, and, within the District, wards 7 and 8.

Figure 40



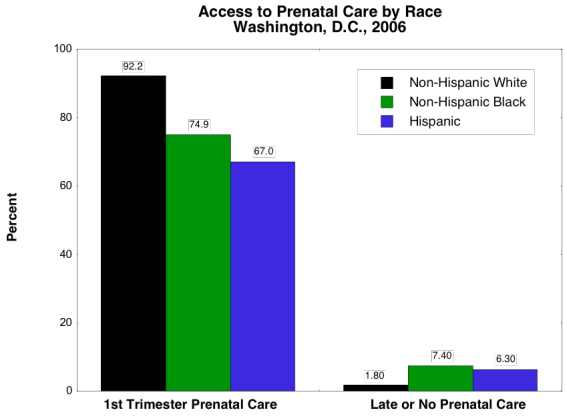
Source: D.C. Department of Health, Center for Planning, Policy, and Epidemiology, State Center for Health Statistics 2010; U.S. Centers for Disease Control and Prevention, National Vital Statistics 2002, 2003, 2004, 2007; National Center for Health Statistics 2009 (DOH 2010a; CDC 2002a, 2003a, 2004a, 2009b; NCHS 2008).

4.2.3. Prenatal Care.

Between 2000 and 2006, the percentage of District births that included first-trimester prenatal care ranged from a low of 74.4 percent in 2001 to a high of 79.5 percent in 2005. While this represents a fairly narrow band, it is notable that the three highest percentages were all recorded in the three most recent years of available data, which suggests that there

has been some improvement. However, as depicted in figure 40, with the exception of 2003, when the nation had an anomalous drop in prenatal care, births in Washington, D.C., were far less likely to have included early prenatal care (CDC 2002a: p. 67, table 34; CDC 2003a: p. 76, table 34; CDC 2004a: p. 74, table 33; CDC 2009b: p.66, table 26[b]; NCHS 2009: pp. 167-169, tables 7 and 8). Nationally, 83.2 percent of women had prenatal care in the first trimester in 2006 (as was also the case in 2000) as compared to 78.8 percent in the District, while only 3.6 percent of women in the U.S. had late or no prenatal care at all.

Figure 41



Source: U.S. Centers for Disease Control and Prevention, National Vital Statistics 2009 (CDC 2009b).

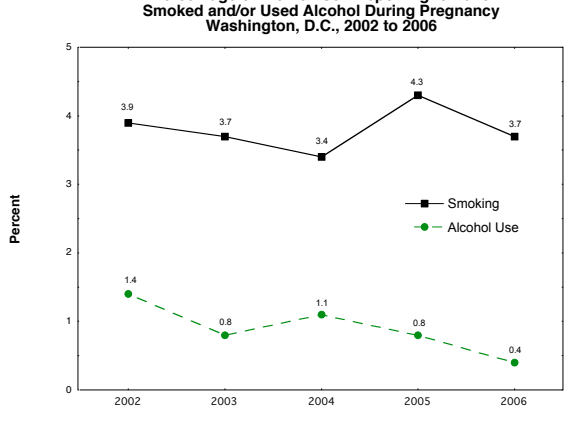
The data on race and ethnicity show that prevalence of prenatal care was not evenly distributed throughout the District. According to the CDC, non-Hispanic white women had the highest rate of first-trimester care (92.2 percent), followed by non-Hispanic black women (74.9 percent). Only 67.0 percent of Hispanic women received this care (figure 41). Not surprisingly, the material on late (defined as beginning in the third trimester) or no prenatal care in 2006 reflect that of early care; only 1.8 percent of non-Hispanic white women received late or no care, while 7.4 percent of non-Hispanic black women and 6.3 percent of Hispanic women received late or no care. Overall, 5.5 percent of women had late or no prenatal care (CDC 2009b).

In sum, while the District has shown some improvement in the frequency of early prenatal care, it still trails the nation as a whole. Furthermore, the use of early prenatal care is even lower for births to non-Hispanic black and Hispanic mothers.

4.2.4. Smoking and Drinking during Pregnancy.

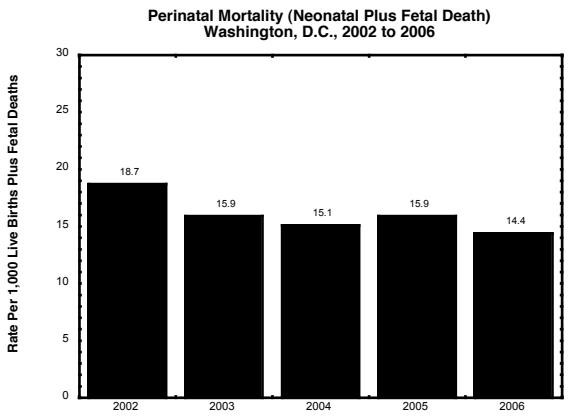
As with a lack of prenatal care, smoking and drinking during pregnancy are associated with poor fetal (post-20 weeks of gestation) and neonatal (up to one month after live birth) health outcomes. With the exception of a small increase in 2004, the percentage of women reporting to have smoked during pregnancy remained about constant between 2002 (3.9 percent) and 2006 (3.7 percent). The percentage of women reporting that they drank alcohol during their pregnancy, already low in 2002 (1.4 percent), was negligible in 2006 (0.4 percent). To the extent that self-reported behaviors can be trusted on behaviors that society clearly deems as unacceptable, the District has done a good job of educating its residents about the dangers of smoking and drinking during pregnancy (DOH 2008i).

Figure 42



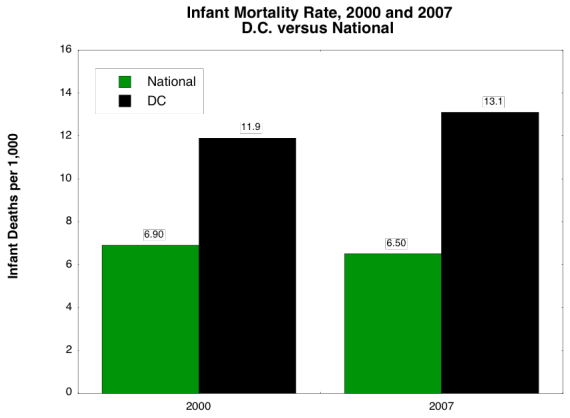
Source: D.C. Department of Health, Center for Policy, Planning, and Epidemiology, State Center for Health Statistics 2008 (DOH 2008i).

Figure 43



Source: D.C. Department of Health, Center for Policy, Planning, and Epidemiology, State Center for Health Statistics 2008 (DOH 2008i).

Figure 44



Source: D.C. Department of Health, Center for Policy, Planning, and Epidemiology, State Center for Health Statistics 2009 (DOH 2009b).

4.2.5. Mortality and Morbidity.

While there are numerous ancillary benefits to reducing teen pregnancy and increasing prenatal care, the ultimate goal is to reduce mortality associated with births. Perinatal mortality, which includes both fetal and neonatal deaths, has fallen by 23 percent from 18.7 per 1,000 live births plus fetal deaths in 2002 to just over 14.4 per 1,000 in 2006, the most recent data available (figure 43). The only year-to-year increase in perinatal mortality over this period was between 2004 (15.1 per 1,000) and 2005 (15.9 per 1,000) when there were, respectively, 121 and 127 perinatal deaths in the District (DOH 2008i). The infant mortality, neonatal and post-neonatal (between one month and a year), rate fluctuated without clearly trending in any direction between 2000 and 2007. The number of deaths of infants one year of age and under was 11.9 per 1,000 live births in 2000. This number dropped to 10.2 per 1,000 in 2003, before increasing again to 11.8 and 13.6 per 1,000 in 2004 and 2005, respectively. In 2006, the rate dropped back to 11.3 per 1,000, but it jumped back up to 13.1 per 1,000 in 2007.

Infant mortality is far more prevalent in Washington D.C. than it is in the nation as a whole (figure 44). As was nearly the case in 2000, the District's infant mortality rate of 13.1 per 1,000 in 2007 was more than twice the national average of 6.5 per 1,000 (DOH 2009b: table 1), and well below the District's goal of 9.4 per 1,000 for that year. Since neonatal mortality is a substantial component of both infant and perinatal mortality, it is likely that the disparity between the nation and the District with respect to infant mortality also exist for perinatal mortality. In any case, a concerted effort is still needed to decrease the mortality and morbidity associated with births in Washington, D.C.

4.2.6. HIV/AIDS.

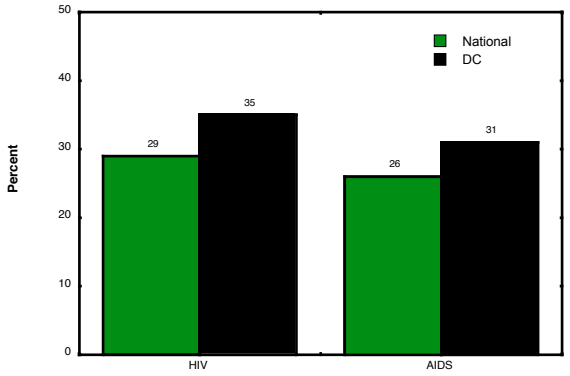
As more women contract HIV/AIDS, the resulting complications will become a greater challenge to healthy pregnancies and births in the District. Between 2001 and 2006, women accounted for roughly one-third of the 6,802 newly reported HIV and AIDS cases in the District of Columbia (DOH 2008a-h). This includes 1,004 women of childbearing age (13 to 49), or 86.9 percent of all women newly reported with HIV. Simultaneously, 1,228 women of childbearing age were newly reported with AIDS, representing 83.7 percent of all such cases for women (DOH 2007). By race, 92 percent of newly reported HIV cases and 94 percent of newly reported AIDS cases among all women were black women.

When compared to the national rate of newly reported HIV and AIDS cases, D.C. reported substantially higher percentages of HIV and AIDS infection among women (Figure 45). Based on national data provided by the U.S. Centers for Disease Control and Prevention (CDC), 35 percent of newly reported HIV cases in D.C. were among women during this time period, compared to 29 percent nationally(DOH 2007; CDC 2002b, 2003b, 2004b, 2005a, 2006). Similarly, newly reported AIDS cases during this period were 31 percent in D.C., versus 26 percent nationally. As with other measures, the distribution of women among newly reported HIV/AIDS cases is not spread evenly throughout the District; it ranges from 21 percent in wards 2 and 3 to 44 percent in Ward 8 (figure 46).

Figure 45

Newly Reported HIV and AIDS That Are Among Women D.C. versus National, 2001 to 2006

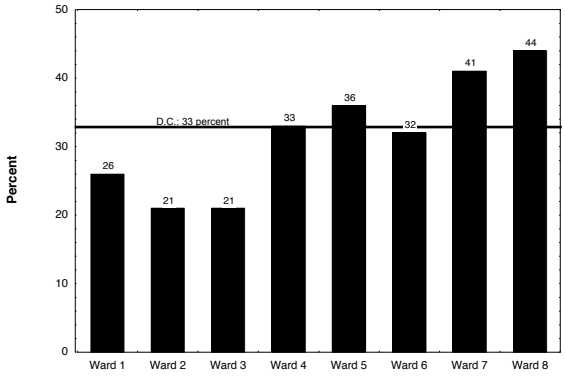
(Figures represent the total number of cases reported from 2001 to 2006 in Washington, D.C. and 2002 to 2006 nationally. National data for 2001 were not available.)



Source: D.C. Department of Health, HIV/AIDS Administration 2007; U.S. Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report 2002, 2003, 2004, 2005, 2006 (DOH 2007; CDC 2002b, 2003b, 2004b, 2005a, 2006).

Figure 46

Percentage of All Newly Reported HIV/AIDS Cases That Are Women, by Ward, Washington, D.C., 2006



Source: D.C. Department of Health, HIV/AIDS Administration 2008 (DOH 2008a-h).

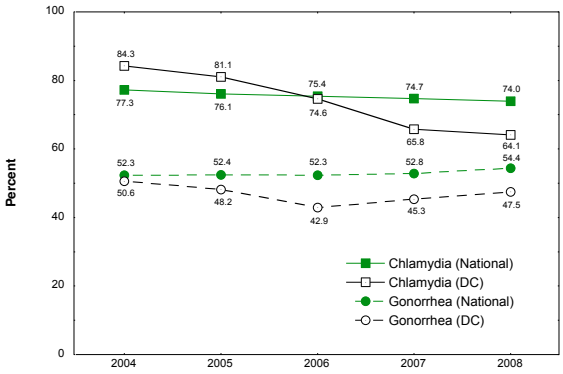
4.2.7. STDs among Women: Gonorrhea and Chlamydia.

Sexually transmitted diseases are yet another key indicator of health for women of child bearing age. It is impossible to draw any conclusions about changes in the actual prevalence of chlamydia over the past few years. Dramatic changes in the manner in which the District tests for the disease have led to the number of cases doubling between 2006 (3,360 cases) and 2007 (6,042 cases) (DOH 2010c: pp. 74, 77, table 19). The improvement in testing has disproportionately improved the ability to detect Chlamydia among men, who saw their rate increase nearly five-fold between 2004 and 2008 (DOH 2010c: p. 77, table 19). Coupling these technological changes with the impossibility of knowing if these changes were employed throughout the country only further complicates the analysis of Chlamydia between 2004 and 2008.

There was a slight increase in the number of gonorrhea cases reported in Washington, D.C. between 2004 (2,570 cases) and 2008 (2,646 cases) (DOH

Figure 47

Percentage of Chlaymdia and Gonorrhea Cases That Were Among Women, 2004 to 2008, D.C. versus National

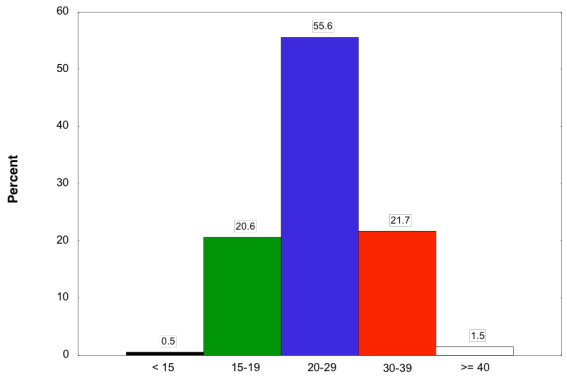


Source: D.C. Department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) 2010; U.S. Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance 2009 (DOH 2010c, CDC 2009d).

2010c: p. 80, table 21). However, as suggested by figure 47, while men in the District saw their gonorrhea diagnoses increase between 2004 and 2008, there was actually a decrease in the number of cases diagnosed in women residing in the District over this time period. Furthermore, compared to women in the U.S., women in Washington, D.C. composed a smaller portion of diagnosed gonorrhea (and Chlamydia) cases than men. However, while the data appear positive for STDs and women in the District, it must be noted that diagnoses are not the same as actual cases. Outreach/screening efforts that disproportionately reach men can just as easily explain the trends observed between 2004 and 2008, as can actual changes in the prevalence of STDs.

Figure 48

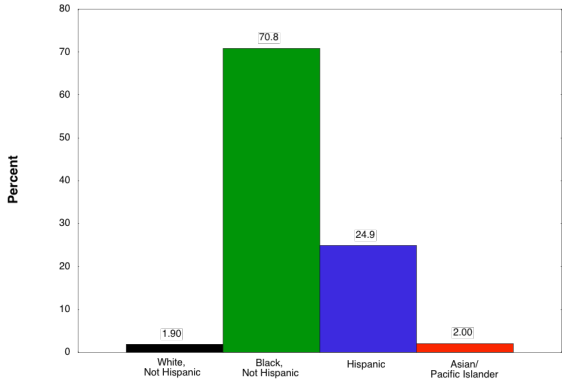
Pregnant Women Enrollees in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) by Age Group, Washington, D.C. 2007



Source: U.S. Centers for Disease Control and Prevention, Pregnancy Nutrition Surveillance System (PNSS) 2008 (CDC 2008r).

Figure 49

Pregnant Women Enrollees in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) by Race/Ethnicity, Washington, D.C. 2007



Source: U.S. Centers for Disease Control and Prevention, Pregnancy Nutrition Surveillance System (PNSS) 2008 (CDC 2008r).

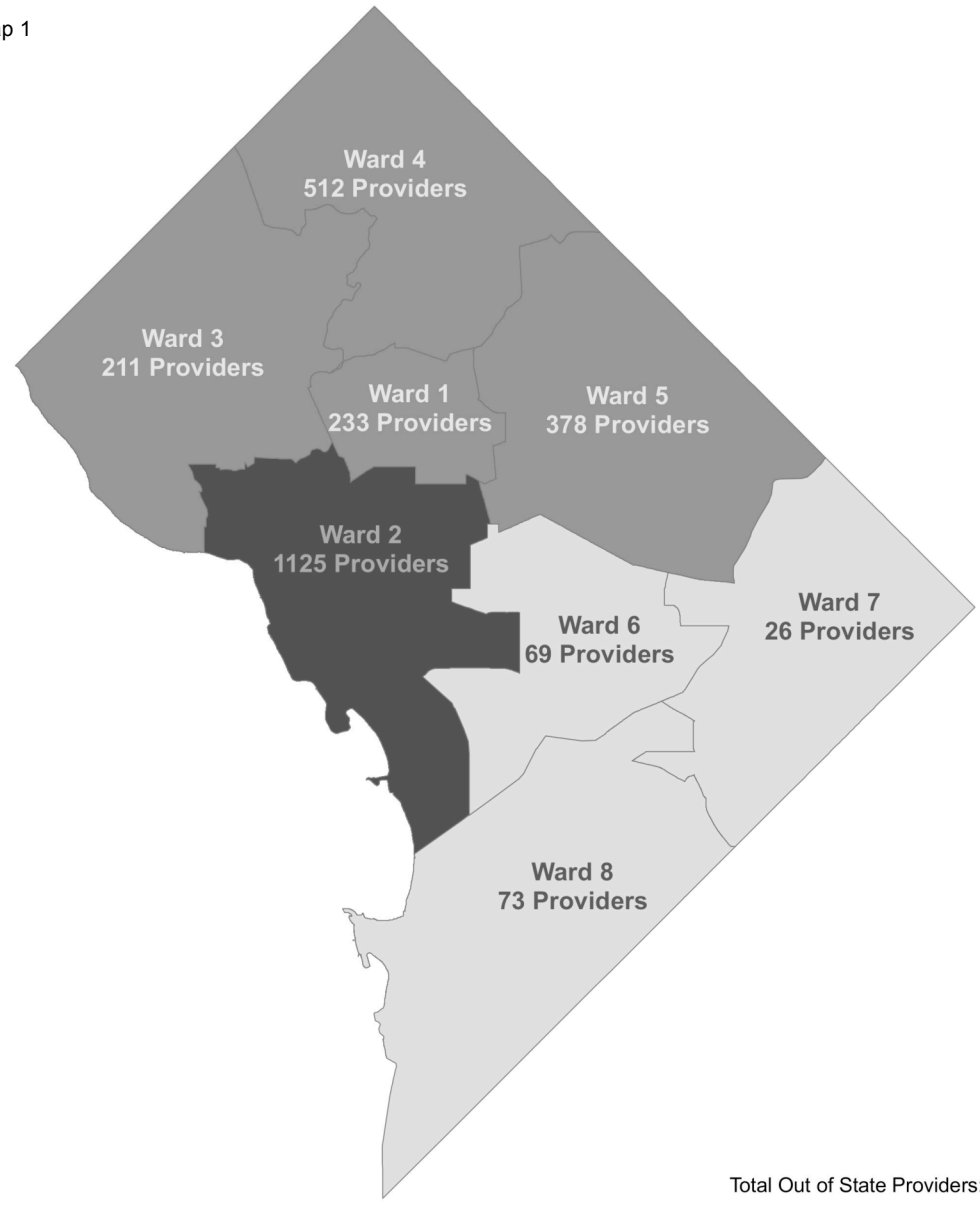
4.2.8. Medicaid and WIC.

One means of determining the population groups that are most likely to benefit or need Title V programming is to review the demographics of the pregnant women who benefit from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). As figure 48 shows, more than half (55.6 percent) of WIC beneficiaries in the District of Columbia are between 20 and 29 years of age. As can be seen in figure 49, more than 95 percent of the pregnant women enrolled in WIC in the District are either non-Hispanic black (70.8 percent) or Hispanic (24.9 percent).

As shown on map 1, there are relatively few health providers that accept Medicaid located in wards 6, 7 and 8, where the economic data (found in the previous chapter) suggest most potential recipients live. In fact, each of the other wards in the district has more Medicaid accepting providers than the wards 6, 7 and 8 combined. As a result many Medicaid recipients must travel away from their neighborhoods for healthcare, this is mitigated by D.C.'s extensive public transit system. Map 2 shows the location of WIC-approved vendors in Washington, D.C., entities that are more evenly dispersed throughout the District.

Health Care Providers Accepting Medicaid
District of Columbia, 2010

Map 1



Total Out of State Providers: 2,054

N
W E
S

0 1 2 Miles

Source:
Office of the Chief Technology Officer (OCTO)

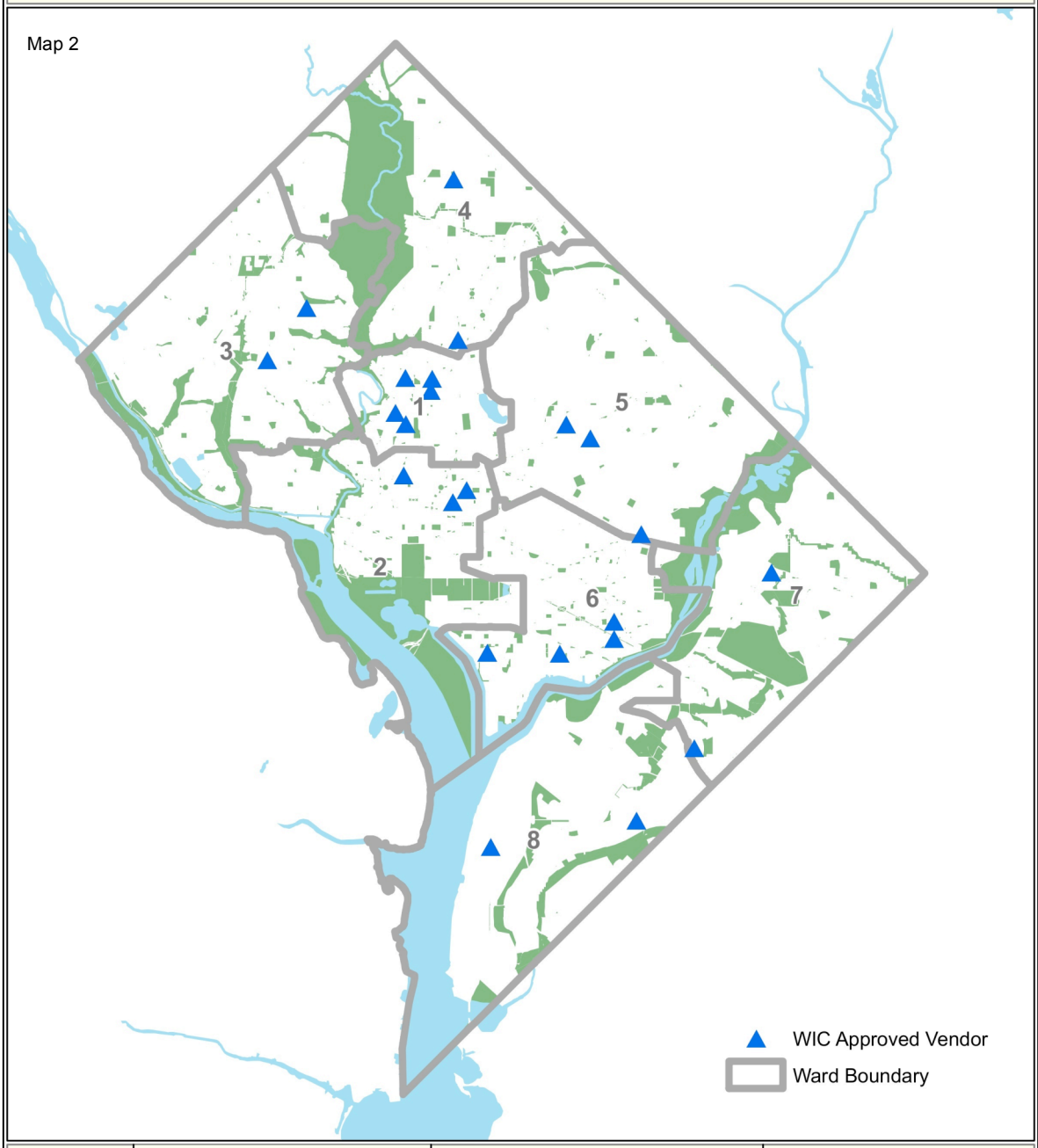
Prepared by: DC GIS

Date: May 11, 2010

Coordinate System:
NAD 1983 StatePlane Maryland FIPS 1900

WIC Approved Vendors, District of Columbia FY 2010

Map 2



N
W E
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0 1 2 Miles

Source:
Office of the Chief Technology Officer (OCTO)

Prepared by: DC GIS

Date: May 7, 2010

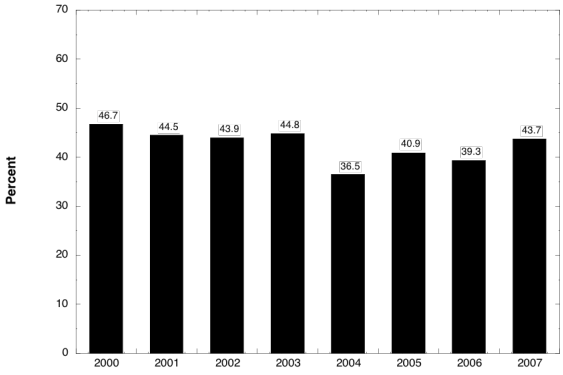
Coordinate System:
NAD 1983 StatePlane Maryland FIPS 1900

Perhaps the best way of measuring continued need for Title V services is to track the number of children accessing it and similar programs throughout the District. After declining by 21.8 percent between 2000 (46.7 percent) and 2004 (36.5 percent), the percentage of children in Washington, D.C. benefiting from federally funded programs for low-income children (figure 50) in 2007 (43.7 percent) was comparable to percentages recorded earlier in the decade (CDC 2008s-t, DCOP 2009). In sum, there is a continuing need in the District for the services provided through Title V, and this is particularly the case for non-Hispanic black and Hispanic residents.

Figure 50

Percentage of Children (< 5) in Federally Funded Programs Serving Low Income Children, Washington, D.C., 2000 to 2007

(E.g., the Special Supplemental Nutrition Program for Women, Infants, and Children; the Early and Periodic Screening, Diagnosis, and Treatment program; and the Title V Block Grant)



Source: U.S. Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, Pediatric and Pregnancy Nutrition Surveillance System (PedNSS/PNSS) 2008; D.C. Office of Planning 2009 (CDC 2008s-t, DCOP 2009).

4.3. Children.

In its 2005 Title V assessment, several priority needs dealing specifically with child well-being were identified. These included improved outcomes regarding oral health, physical activity and nutrition, violence toward and by children, sexually transmitted disease screening and prevention, asthma management and lead poisoning. This section will update the District's status with regard to these indicators.

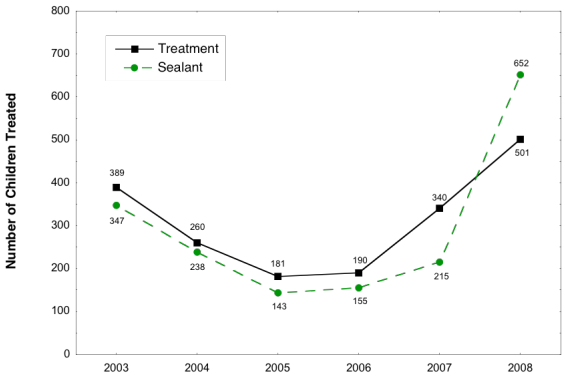
4.3.1. Oral Health.

Nationally, about 20 million children are considered high-risk, high-prevalence, high-severity when it comes to pediatric tooth decay. This group has historically been largely made up of low-income children, nearly all of whom are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) (NIH 1996). At particular risk are African-Americans and Hispanics.

While many of these children are eligible for Medicaid, some families are not aware of the full scope of their benefits. For others, access to services is a problem, which has been noted in focus groups held for this needs assessment. Availability of dental providers is considered a problem in the District, as few accept children with pediatric Medicaid dental payments. Even when care is available, it tends to be limited to preventive and basic screening care, rather than intervention (RAND 2009).

Figure 51

School-based Oral Health Programs, 2nd and 3rd Graders Who Received Treatment and Sealants Washington, D.C., 2003 to 2008



Source: D.C. Department of Health, Community Health Administration, Oral Health Division 2009 (DOH 2009c).

The Washington School Based Oral Health program has been selecting schools for treatment and sealant programs since the 2003-2004 school year. During the 2008-2009 school year, by far its most successful thus far, this program provided 652 2nd and 3rd graders with sealants and provided general treatment to 501 students (figure 51). Both of these numbers represent

improvements over the previous school year, when 215 students received sealants and 340 got general treatments. During the 2008-2009 school year, the program treated 62 percent of total 2nd and 3rd graders in wards 7 and 8, but within the specific schools visited, it placed sealants on the teeth of 81 percent (DOH 2009c).

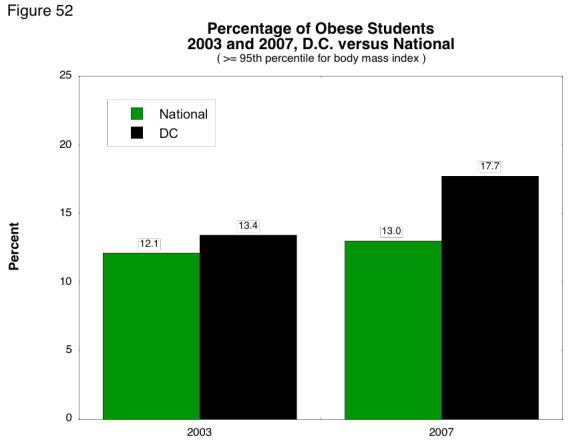
4.3.2. Physical Activity and Nutrition.

The CDC's Youth Risk Behavior Survey (YRBS) is conducted every two years in public schools around the country to monitor priority health risk behaviors that contribute to the leading causes of death, disability and social problems among youth and adults in the United States. In order to assess children's health in D.C. as it pertains to dietary behaviors and lifestyles, the following YRBS measures regarding physical activity and nutrition were assessed:

- Obesity among adolescents.
- Students getting 60 minutes of physical activity per day.
- Consumption of fruits and vegetables.

The YRBS attempts to determine the percentage of high school students within a given area who are obese. Respondents are evaluated based on their body mass index (BMI) to identify the percentage that are considered obese or overweight (greater than or equal to the 95th percentile for body mass index is considered obese). In the District of Columbia, the percentage of high school students classified as obese increased significantly from 13.4 percent in 2003 to 17.7 percent in 2007 (figure 52 and table 19). Nationally, significantly fewer (13.0 percent) high school students were considered obese in 2007. This in contrast to 2003, when the difference between the percentages of high school students deemed obese in the District and in the nation (12.1 percent) was not significant (CDC 2007c).

Figure 52



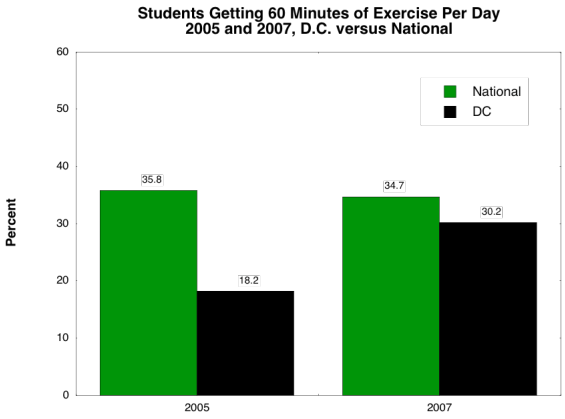
Source: U.S. Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS) 2007 (CDC 2007c).

Whether broken down by race/ethnicity, gender or grade, all groups in the District had higher reported percentages of obesity in 2007 than they had in 2003. In the case of blacks, females, 11th graders, and females in 11th grade, these differences were statistically significant (table 20). Obesity, a growing challenge for the entire nation, is a particularly acute problem in the District. While only a few groups had changes that reached significance, the fact that no group had a decline in reported obesity between 2003 and 2007 is telling.

In order to gauge the amount of exercise children are getting, the YRBS also asks students whether they participated in 60 minutes of physical activity that "increased their heart rate and made them breathe hard some of the time" for at least 5 of the 7 days prior to the survey. In D.C., as seen in figure 53, in 2007 30.2 percent of students overall reported that they had participated in this amount of exercise (26.0 percent for females and 33.9 percent for males) (CDC 2007d). Compared to the national rate of 34.7 percent, D.C. public high school students were significantly less likely to participate in the recommended level of routine physical exercise in 2007, as was

the case in 2005 (table 19). Despite this, 2007 data on this measure represent encouraging increases overall compared to 2005, and by gender and race.

Figure 53



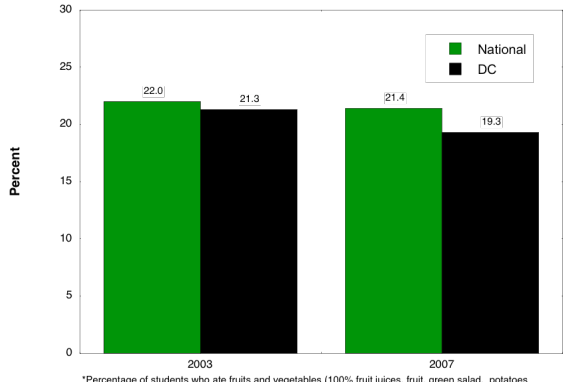
Source: U.S. Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS) 2007 (CDC 2007d).

Significantly more high school students in Washington, D.C. reported engaging in the recommended amount of physical activity in 2007 than did in 2005 (18.2 percent). Over this period, every sub-group by gender, race/ethnicity and grade level also reported an increase in the physical activity. By gender, significant increases were witnessed from 2005 to 2007 for both sexes, from 14.2 percent to 26.0 for females, and from 22.5 percent to 33.9 for males (table 20). Broken down by race, significant increases in physical activity were seen among black females (from 14.5 percent to 26.3) and males (from 23.0 percent to 35.6) from 2005 to 2007. A significant increase was also seen for Hispanic students (from 11.9 percent in 2005 to 21.3 in 2007).

The YRBS also assesses nutritional behaviors by surveying students to learn whether they have eaten fruits or vegetables five or more times per day in the previous seven days. According to the 2007 survey, 19.3 percent of D.C. students met this objective, compared to 21.4 percent of high school students nationally (figure 54); the difference between the two sets of students was not significant in 2007 or 2003 (table 19), nor was the difference between fruit consumption in 2007 and 2003 (21.3 percent). The largest group claiming to have eaten five or more servings of fruits and vegetables per day in the last seven days in 2007 was black males, at 20.4 percent; black females were at 17.2 percent.

Results from 1999 to 2007 show a steady and significant decrease in total fruit and vegetable consumption among D.C. students, from 28.6 percent in 1999 to 19.3 in 2007. Much of the decrease in fruit and vegetable consumption occurred between 1999 and 2003. While reported consumption has continued to decline, the difference between 2003 and 2007 levels (unlike the earlier period) was not significant.

Figure 54



*Percentage of students who ate fruits and vegetables (100% fruit juices, fruit, green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables) five or more times per day during the 7 days before the survey.

Source: U.S. Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS) 2007 (CDC 2007e).

Results by race mimic these results in all cases except for black females, who have experienced a recent increase, from 16.7 percent in 2005 to 17.2 in 2007 (CDC 2007e). The rate for Hispanic students decreased significantly from 42.2 percent in 1999 to 17.5 percent in 2007. Similarly, the rate for students of all other races (non-black or non-Hispanic) decreased, though not significantly (due to a limited sample size) from 35.6

percent in 2005 to 19.4 in 2007. While high school students are now engaging in more physical activity, this is being offset by increasingly poor diets and an increase in obesity that is likely related to the latter.

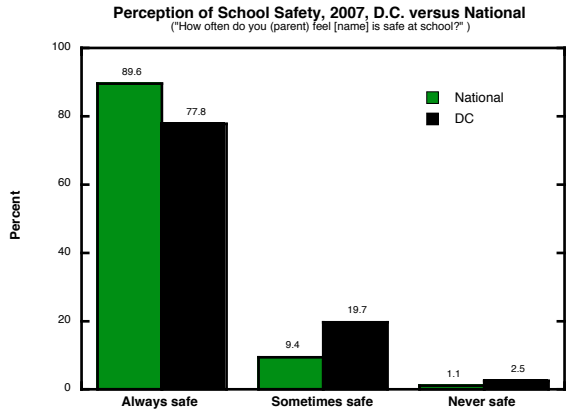
4.3.3. Violence toward and by Children.

To assess the status of child safety as a result of violence and/or abuse, the following measures were analyzed:

- Perception of school safety.
- High school students in a physical fight one or more times.
- High school students who carried a weapon in the last 30 days.
- Instances of child abuse and/or neglect.

The Maternal and Child Health Bureau of the U.S. Department of Health and Human Services sponsored the National Survey of Children's Health (NSCH) in 2003 and 2004, and again in 2007 and 2008. This survey provides a range of information regarding child health and well-being throughout the United States, based on the results of 91,642 surveys that were completed for children from birth to age 17 (NSCH 2007). For the purpose of this assessment, survey results regarding school safety were used to analyze the overall perception of safety in schools among D.C. public school students compared to children around the country.

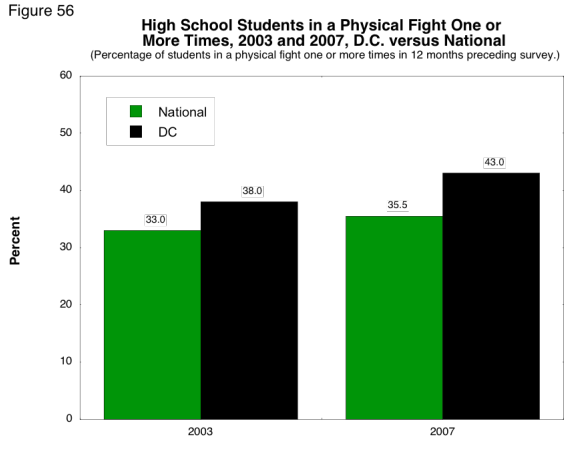
Figure 55



Source: Child and Adolescent Health Measurement Initiative, National Survey of Children's Health 2007 (NSCH 2007).

The 2007 NSCH revealed that 77.8 percent of children ages 6 to 17 in the District of Columbia claimed they "usually or always" feel safe at school. Results also indicated that 19.7 percent of children ages 6 to 17 only feel safe "sometimes," and 2.5 percent claim to "never feel safe." Compared to national averages (figure 55), D.C. children ages 6 to 17 were significantly less likely to report they "always" feel safe in school (table 19), and more than twice as likely to claim that they only "sometimes" feel safe compared to national averages in 2007 (NSCH 2007).

Figure 56



Source: U.S. Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS) 2007 (CDC 2007a).

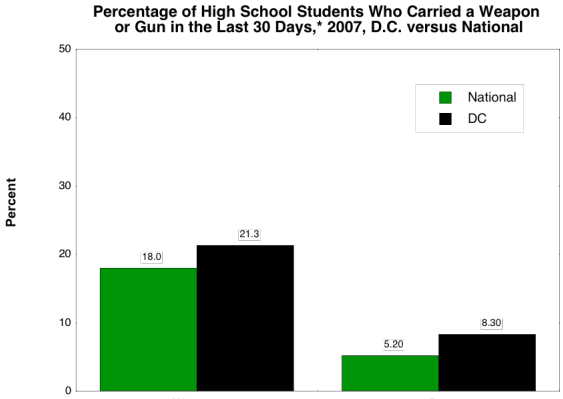
The YRBS provides data regarding a variety of violent behaviors, including the percentage of high school students in a physical fight one or more times during the 12 months prior to the survey. As seen in figure 56, results among D.C.

public school students (grades 9 through 12) show that 43.0 percent reported having been in a physical fight one or more times within the past 12 months in 2007. Compared to the national average of 35.5 percent, D.C. high school students were significantly more likely to have been in a physical fight in the year preceding the 2007 survey (table 19). The District's 2007 percentage was also significantly higher than what high school students reported in 2003 (38.0 percent) (CDC 2007a).

Results by grade showed that 9th graders reported being in a physical fight more than students from other grades for each year the survey was administered. The results for 2007 indicated that 48.7 percent of 9th graders, 46.3 percent of 10th graders, 39.9 percent of 11th graders and 31.9 percent of 12th graders reported having been in a physical fight within the year prior to the survey. Not surprisingly, given the differences between students who progress through school and those who do not, this downward trend by grade was witnessed each year the survey was administered. The only grade level in Washington, D.C. to not report more physical fights in 2007 than it had in 2003 was 12th grade, though none of the differences was statistically significant. There was a significant increase in reported physical fights for black students (and for black 9th graders, in particular) between 2003 and 2007 (table 20).

The YRBS also monitors the percentage of high school students who carried a weapon on at least one day during the 30 days before the survey (including a gun, knife or club), as well as those who specifically carried a gun during the same period. In the District of Columbia, 21.3 percent of high school students reported carrying a weapon during the 30 days immediately prior to participating in the 2007 survey (CDC 2007b); this percent was significantly higher than that reported by high school students in the nation as a whole, 18.0 percent (figure 57 and table 19).

Figure 57

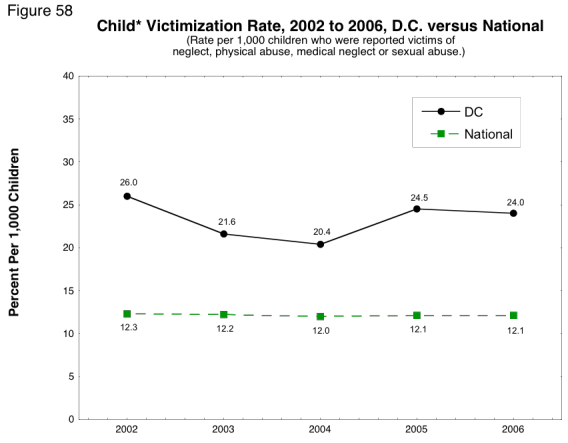


The District has seen a significant decline in high school students reporting possession of a weapon over time (from 33.5 percent in 1993 to 21.3 percent in 2007). Results by gender reveal that significantly more males than females claim to have carried a weapon in the 30 days prior to each year's survey. Among females, results ranged from 27.4 percent in 1993 to 16.4 in 2007. Results for male students ranged from 40.9 percent in 1993 to 27.0 percent in 2007. However, over the last two years the percentage of male students that claimed to have carried a weapon jumped significantly, from 19.4 percent in 2005 to 27.0 percent in 2007 (table 20).

By grade, 10th and 12th graders were most likely to report having carried a weapon in the last 30 days (23.6 percent and 23.5 percent, respectively) during the 2007 survey. While, as noted above, there was a significant decrease in students reporting weapons since 1993 (seen across all grade levels), almost all of this positive change occurred prior to 2005. More recent data revealed significant increases on this indicator between 2005 and 2007 for both 9th (18.0 to 20.7 percent) and 12th (9.2 to 23.5 percent) grade students in Washington, D.C.

Students were also asked specifically if they had carried a gun during the 30 days leading up to the survey (figure 57). After witnessing a decrease from 13.7 percent in 1993 to 4.9 percent in 2005, the percentage of D.C. high school students reporting that they carried a gun over the 30-day period preceding the 2007 survey rose to 8.3 percent. Results by gender indicated that male students were much more likely to carry a gun in 2007 (14.2 percent) than females (2.6 percent). Data by race show that, while African-American students were most frequently reported carrying a gun during the first few years of the YRBS survey, by 2007 Hispanic students were most likely to do so (8.5 percent) (CDC 2007b).

Figure 58



Child abuse has long been a national concern. In the District of Columbia, the number of children who were victims of abuse dropped from a recent high of 26.0 per 1,000 in 2002 to a low of 20.4 in 2004 (figure 58). However, according to the U.S. Department of Health and Human Services, that figure had risen to 24.0 in 2006 — nearly twice the national average. The majority of these cases (57.8 percent) in the District of Columbia were categorized as neglect, followed by physical abuse, which totaled 14.7 percent (DHHS 2008).

Overall, after a sustained period of significant improvement on most measures of safety for nearly all groups of high school students in the District, data subsequent to 2005 suggest that a reversal is currently underway. This coupled with the fact that District high school students, even during the period of improvement, remained far less likely to report being safe (or engaging in safe behavior) than students from the nation as a whole, suggest that safety remains a key area of need for Title V recipients.

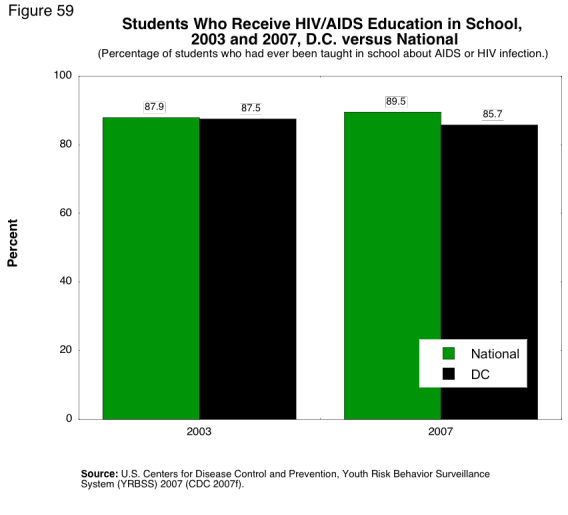
4.3.4. Sexually Transmitted Disease Screening and Prevention.

Several measures were incorporated in an attempt to monitor the District's recent performance in reducing sexually transmitted diseases (STDs). These measures included:

- HIV/AIDS education in schools.
- Chlamydia prevalence.
- Gonorrhea prevalence.
- Condom use.

According to the YRBS, 89.5 percent of students in the United States reported being taught about acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)

Figure 59

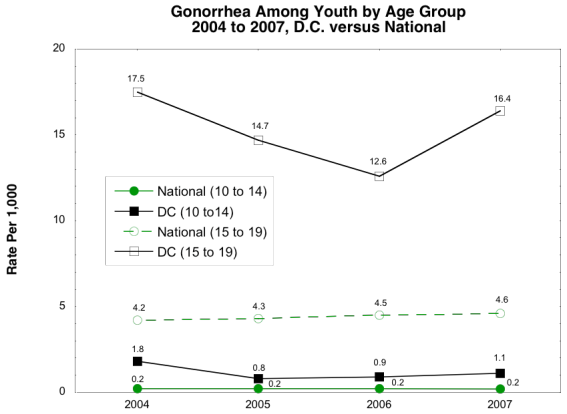


infection in school in 2007 (figure 59). This statistic was rather higher (91.1 percent) among white students (CDC 2007f). By comparison, 85.7 percent of all high school students in the District of Columbia reported having been taught about HIV/AIDS that same year. Keeping in mind the previously referenced high rates for HIV and AIDS in the District, this would appear to be an area of potential improvement.

Within the District, rates of gonorrhea, chlamydia and syphilis are all above the national rates among children 10 to 14 years old. Nationally, in 2007 the rate of gonorrhea for children ages 10 to 14 was 0.2 percent, figure 60 (CDC 2009d: table 20). In the District the rate was 1.1 percent in 2007, up from 0.9 percent in 2006, though still lower than the 1.8 percent seen in 2004. Among 15 to 19 year olds, rates tend to be higher. Nationally, the rate is 4.6 percent, while in the District in 2007 it was 16.4, more than three times the national rate. This is, again, higher than the 12.6 percent seen in 2006, but down from a high of 17.5 in 2004. The average national rate for chlamydia in 2007 was 0.6 percent among 10 to 14 year olds and 17.8 among 15 to 19 year olds, figure 61 (CDC 2009d: table 10). Among 10 to 14 year olds in the District, the rate in 2007 was 3.8 percent, but it jumped to 56.0 percent among 15 to 19 year olds. It should also be kept in mind that, as these numbers were generated based on culture-positive reports made to the D.C. Department of Health, they may underestimate the true prevalence of these sexually transmitted infections (STIs), particularly among teens who were treated clinically without cultures, and who thus went unreported (RAND 2009).

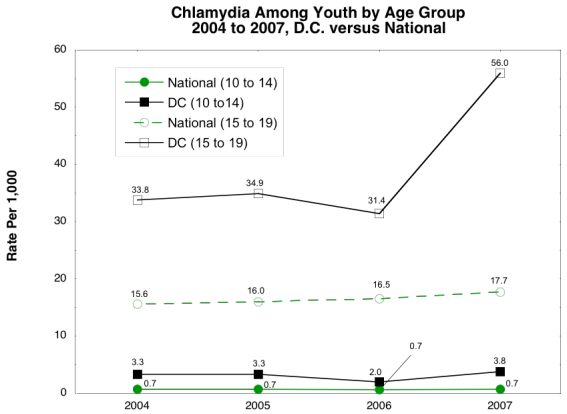
One of the most effective means of preventing STDs and STIs, aside from abstinence, is through the use of condoms. As seen in figure 62, although

Figure 60



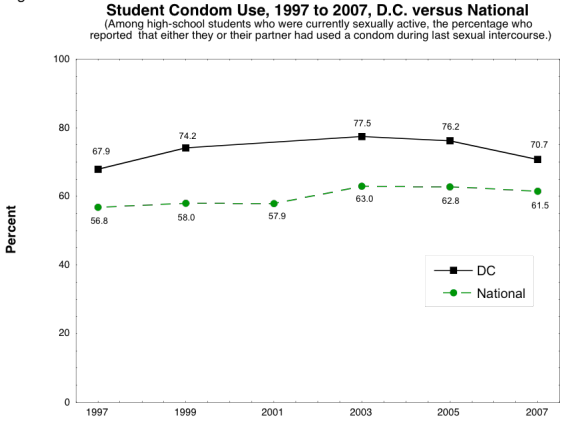
Source: RAND Corporation 2009; U.S. Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance 2008 (RAND 2009, CDC 2009d).

Figure 61



Source: RAND Corporation 2009; U.S. Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance 2009 (RAND 2009, CDC 2009d).

Figure 62



*The 2001 figure for the District of Columbia is not available.

Source: U.S. Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS) 2008 (CDC 2008u).

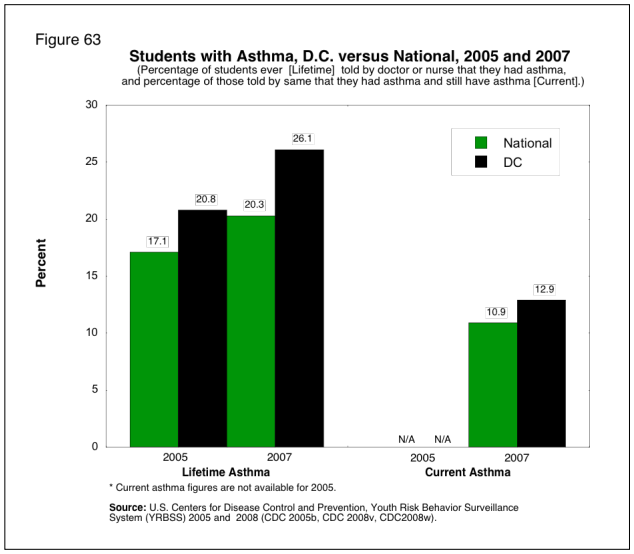
the District has been witnessing a slight decline in condom use recently, it is still significantly above the national average. Between 1997 and 2007, the number of District high school students who reported using condoms fluctuated between a high of 77.5 percent in 2003 and a low of 67.9 percent in 1997. In 2007, 70.7 percent of respondents reported using condoms during their last episode of intercourse, a percentage that was significantly higher than that of national respondents (61.5 percent). During most years, there has been over a 10-percentage-point higher use of condoms among D.C. teens than in the entire United States, and the difference was significant for each year that there were data for both D.C. and the U.S. (table 19). The only year when there were fewer than 10 percentage points between the two numbers was 2007 (CDC 2008u).

Whether categorized by gender or by grade, District students reported more condom use during last sexual intercourse than did student in the nation as a whole. In the District, the 70.7 percent of condom usage breaks down to 67.3 percent for females and 73.8 percent for males. Nationally, 54.9 percent of females overall reported using a condom, compared to 68.5 percent of males. As these data suggest, female respondents in the District were significantly more like to report condom use than were females nationally (table 20). More males reported condom use in Washington, D.C. than in the U.S., but the difference was not significant. Broken down by grade, all grade levels in the District of Columbia reported more condom use during last sexual intercourse in 2007, than their respective counterparts nationally. Condom use among D.C. 9th graders was reported at 69.3 percent (61.0 percent by females and 75.8 percent by males). This figure drops to 66.1 percent in the 10th grade (59.5 percent for females and 73.2 percent for males). However, even with this lower percentage, 10th graders in Washington, D.C., were significantly more likely to report condom use than 10th graders in the U.S. Among 11th graders, usage was reported at 62.0 percent (55.1 percent for females and 69.3 percent for males), while 12th grade students (54.2 percent overall) were the least likely to report condom use in 2007 (49.9 percent for females, and 59.6 percent for males).

4.3.5. Asthma.

Asthma sufferers can be broken down into two categories: lifetime sufferers and current sufferers. Lifetime asthma sufferers include all individuals who have *ever* been told by a doctor or nurse that they have asthma, while current asthma sufferers are those who have been told by a doctor or nurse that they *currently* have asthma. In the District of Columbia, 26.1 percent of high school students were defined as having lifetime asthma and 12.9 percent were categorized as having current asthma in 2007 (figure 63). Both numbers were significantly higher than their respective national percentages (table 19).

Nationally, 20.3 percent of students reported lifetime asthma and 10.9 percent reported current asthma in 2007 (CDC 2005b, 2008v, 2008w).

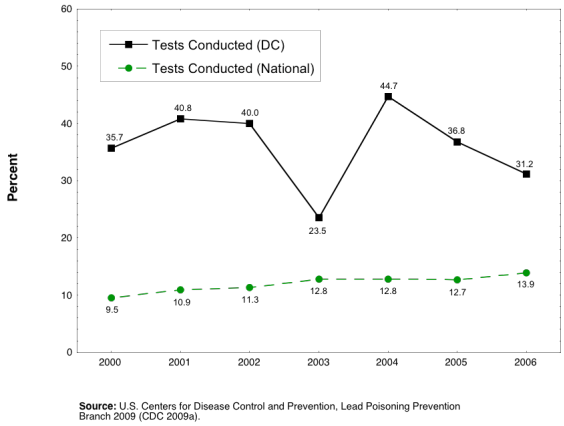


By gender, both female (24.1 percent) and male (27.7 percent) youth were significantly more likely to report lifetime asthma in Washington, D.C. in 2007 than were their female (20.7 percent) and male (19.9 percent) counterparts in the nation as a whole (table 20). While female and male youth in the District were also more likely to report currently having asthma than were females and males nationally in 2007, the

difference was not significant in either instance. While black youth were significantly more likely to report both lifetime and current asthma than their Hispanic counterpart within the District, there were no significant differences between the lifetime or current asthma reporting percentages for black or Hispanic youth from Washington D.C., and that of black or Hispanic youth, respectively, in the nation as a whole. This suggests that the afore-noted disparity between the District and national lifetime asthma percentages is the result of differing demography, as contrasted to geography. According to the *Burden of Asthma in the District of Columbia 2009* report, current asthma prevalence was more than two times higher among respondents reporting an annual household income of less than $15,000 than those reporting an annual income above $75,000 in 2007 (DOH 2009e). However, as income differences are also seen by race, it is not possible, with the evidence available, to disaggregate racial differences in asthma from economic differences.

While the lifetime and current asthma data have not been positive, there is evidence that there has been a reduction in acute cases of asthma over the past decade. According to the District of Columbia Hospital Association, the frequency of asthma-related hospital discharges for both adults and children in the District has decreased consistently from 1,525 in 1997 to 1,087 in 2005, a 28.7 percent decrease. In 2000, the report indicates that there were 425 children (less than 18 years of age) who were discharged from D.C. hospitals after having been admitted for asthma. By 2005 this number decreased to 267, a drop of 37.2 percent (DOH 2009e).

Figure 64



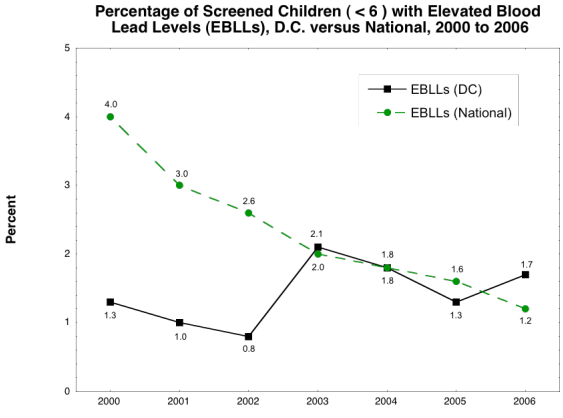
Source: U.S. Centers for Disease Control and Prevention, Lead Poisoning Prevention Branch 2009 (CDC 2009a).

4.3.6. Lead Poisoning.

Two measures were examined in an attempt to assess the District's progress in decreasing lead poisoning for children under six years of age. They were:

- Lead tests conducted on children under age six.
- Children under age six with elevated blood lead levels (EBLL).

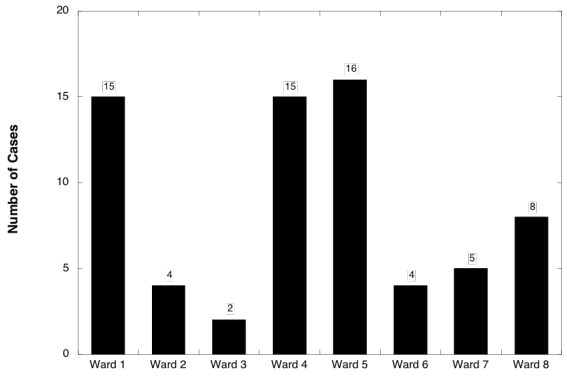
Figure 65



Source: U.S. Centers for Disease Control and Prevention, Lead Poisoning Prevention Branch 2009 (CDC 2009a).

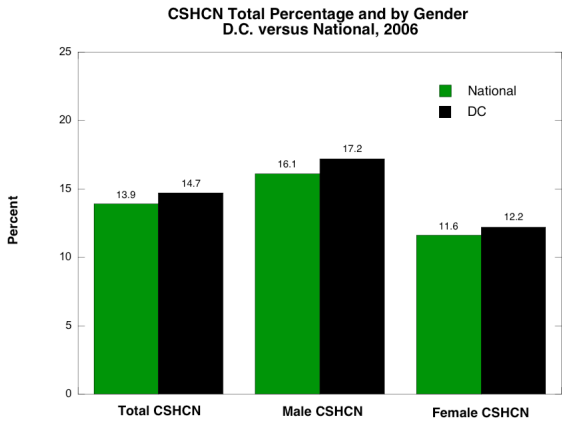
The most common sources of lead poisoning in children are lead-based paint and lead-contaminated dust in older buildings (MC 2009). Even a small amount of lead can cause health problems and severely affect mental and physical development. If lead levels become elevated enough, the results can be fatal. EBLL is defined as 10 or more micrograms of lead per deciliter of blood (mcg/dL). The first step in preventing health problems that result from EBLL is to test for lead in the blood.

Figure 66



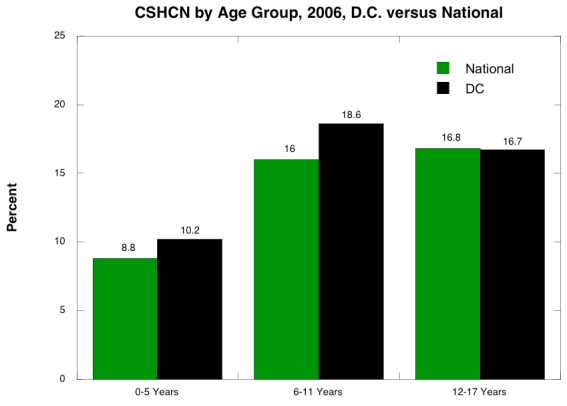
Source: Government of the District of Columbia, District Department of the Environment, Lead and Healthy Housing 2009 (DOE 2009).

Figure 67



Source:U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children with Special Health Care Needs 2008 (HRSA 2008).

Figure 68



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children with Special Health Care Needs 2008 (HRSA 2008).

As depicted in figure 64, 31.2 percent of children under age six in Washington, D.C. were tested for EBLL in 2006. This was the second lowest percentage for the District since 2000, and it is part of a sharp downward trend since 2004. However, 2003 (when only 23.5 percent of the District's children under 6 were tested) was the only year that the percentage of children tested for EBLL in the District was not at least twice as high as the national percentage (CDC 2009a). The difference in testing levels may be a result of differences in perceived risk.

As seen in figure 65, of the more than three million children under age six in the U.S. tested for lead in 2006, 1.2 percent had confirmed elevated blood lead levels. In the District that same year, the EBLL number was 1.8 percent — i.e., 50 percent higher than the national percentage (CDC 2009a). While the number of tested children with EBLL has steadily decreased between 2000 and 2006, during this same period, 2004 and 2006 were the years with the highest number of cases in the District. By ward, the highest number of cases of children under six with EBLL in 2009 were found in Ward 5, followed by wards 1 and 4 (figure 66). The lowest incidences can be found in Ward 3, followed by wards 2 and 6. Caution should be taken when drawing conclusions about cases by wards, as the data on the percentage of children tested in each ward are not available as yet.

4.4. Children with Special Health Care Needs.

Among the District's Title V priority needs from 2005 is increasing access to medical homes for children with special health care needs and supporting seamless systems of care.[6] According to

[6] According to the American Academy of Pediatrics, a medical home has care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."

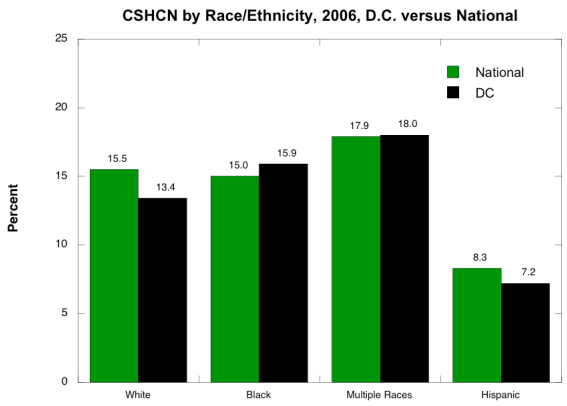
U.S. Department of Health and Human Services' (HHS) *National Survey of Children with Special Health Care Needs* (conducted in 2005 and 2006), 14.7 percent of children in Washington, D.C., have special health care needs, higher than the 13.9 percent found nationally (figure 67). Results by gender reveal that there are significantly more male children with special needs (17.2 percent) than female (12.2 percent) in D.C. These results, although higher than national averages, mimic the higher concentration of male special needs children throughout the country (HRSA 2008).

As shown in figure 68, results from the HHS 2006 survey reveal that in D.C. an estimated 10.2 percent of children birth to age 5, 18.6 percent of children ages 6 to 11, and 16.7 percent of children ages 12 to 17 are classified as having special health care needs. The figures for ages 6 to 11 are approximately 2.6 percentage points higher than the national average, while the percentage for ages 12 to 17 is slightly below the national average (HRSA 2008).

From the perspective of race (figure 69), there are lower percentages of white and Hispanic special needs children in D.C. (13.4 and 7.2 percent, respectively) than are found nationally (15.5 and 8.3 percent, respectively). And when breaking the District down by ward (figure 70), according to a recent RAND report that looked at Medicaid-receiving children in one specific program operated by Hospital for Sick Children, wards 7 and 8 are home to the highest number of children with special needs, totaling 606 and 861, respectively (DOH 2009d).

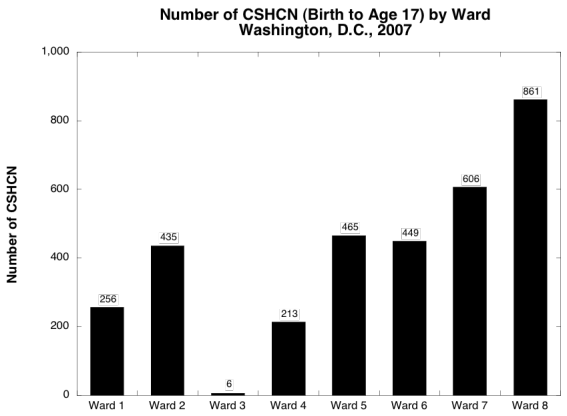
When looking at the percentage of families with CSHCN that report having adequate private and/or public insurance to pay for the services they need, only 55.9 percent of D.C. families with CSHCN reported this to be the case in 2001, compared to 59.6 percent

Figure 69



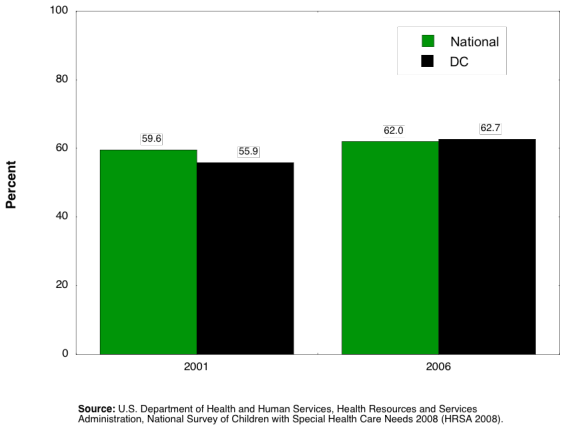
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children with Special Health Care Needs 2008 (HRSA 2008).

Figure 70



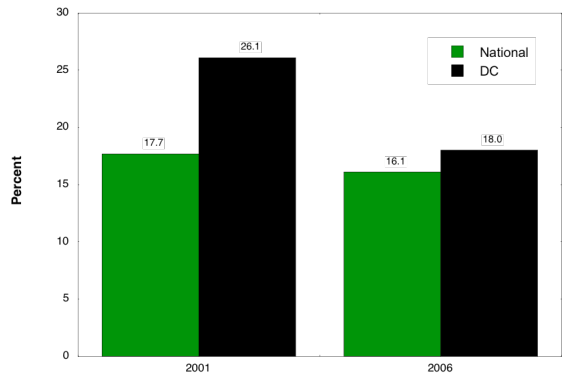
Source: D.C. Department of Health, Community Health Administration, Data Analysis and Program Evaluation Division 2009 (DOH 2009d).

Figure 71



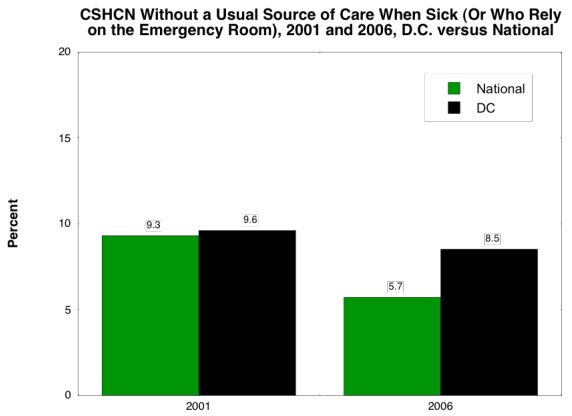
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children with Special Health Care Needs 2008 (HRSA 2008).

Figure 72



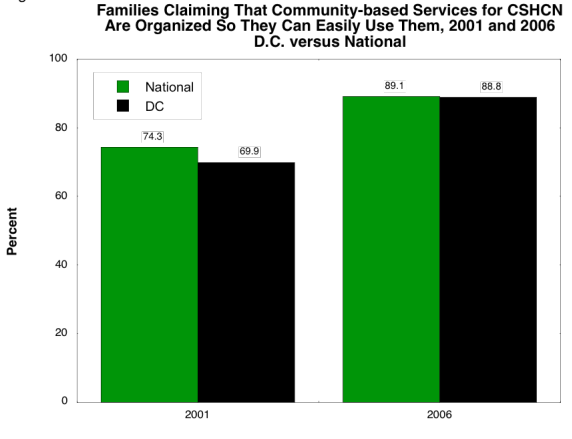
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children with Special Health Care Needs 2008 (HRSA 2008).

Figure 73



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children with Special Health Care Needs 2008 (HRSA 2008).

Figure 74



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children with Special Health Care Needs 2008 (HRSA 2008).

nationally (figure 71). But by 2006 Washington, D.C., had surpassed the national figure, with 62.7 percent of D.C. families with CSHCN reporting having adequate health insurance, compared to 62.0 percent of families nationwide.

Access to care is an important issue for families with CSHCN, and in this regard the District appears to have made considerable improvement. When asked whether they had any unmet needs for specific health-care services in 2006, a slightly higher percentage of Washington, D.C., families of CSHCN replied in the affirmative (18.0) than did families nationally (16.1 percent) (figure 72). However, in 2001 the difference was much greater, 26.1 percent replying in the affirmative in D.C. compared to 17.7 percent nationally (HRSA 2008).

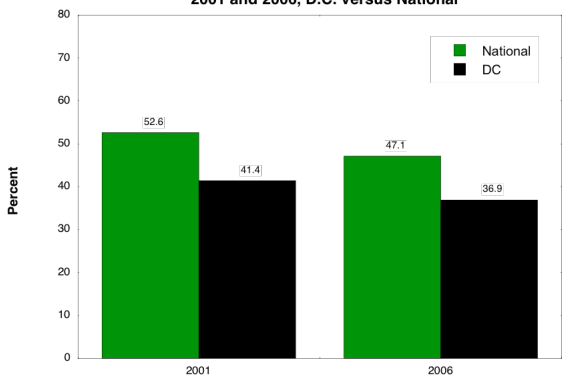
In 2001, nearly the same percentage of families of CSHCN in the District (9.6 percent) reported not having a usual source of care when sick or relying upon the emergency room as did those nationally (9.3 percent). As illustrated in figure 73, by 2006 the disparity was greater, with 8.5 percent of CSHCN families in Washington, D.C. saying they were without a usual source of care when sick, compared to 5.7 percent nationally. So although some progress was realized between 2001 and 2006, it lagged behind that realized nationally (HRSA 2008).

On the positive side, the District has nearly caught up with the nation as a whole when it comes to measuring whether or not community-based services for CSHCN are organized so families can use them easily. As shown in figure 74, in 2001 69.9 percent of families with CSHCN reported this to be the case, compared to 74.3 percent nationally. By 2006, that number had risen to 88.8 percent in Washington, D.C., just under the 89.1 percent reported nationally (HRSA 2008).

The data are not quite as encouraging when it comes to CSHCN receiving coordinated, ongoing, comprehensive care within a medical home, however. On this important measure the District lagged significantly behind the nation in 2001 (41.4 percent in D.C. compared to 52.6 percent nationally), and the situation was largely the same in 2006 (figure 75), when both the nation and the District were performing worse than in the previous study (36.9. percent in D.C. versus 47.1 percent nationally). Just as increasing access to medical homes was a priority for the District following its 2005 Title V needs assessment, this will likely continue to be the case following the current needs assessment process (HRSA 2008).

Figure 75

Families of CSHCN Claiming to Receive Coordinated, Ongoing, Comprehensive Care Within a Medical Home 2001 and 2006, D.C. versus National

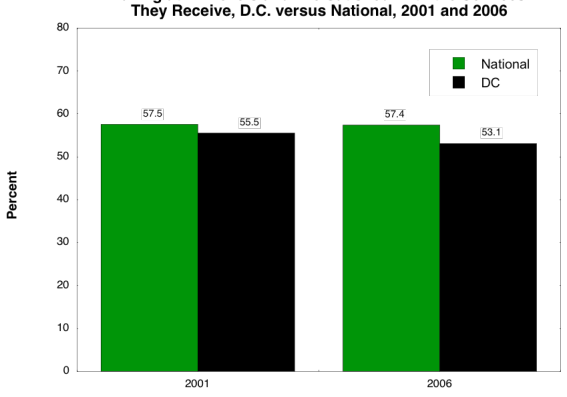


Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children with Special Health Care Needs 2008 (HRSA 2008).

Another measure of vital importance to families of CSHCN is whether they feel they partner in decision making at all levels and are satisfied with the services they receive. On this indicator, Washington appears to be performing about the same as the nation as a whole; however, there has been a slight decrease in the percentage of D.C. residents agreeing that they are partners between 2001 and 2006 (figure 76). In 2001, 55.5 percent of D.C. families with CSHCN reported being partners in decision making and satisfied with services, compared with 57.5 percent nationally. By 2006 that number had fallen to 53.1 percent in D.C. and 57.4 percent nationally (HRSA 2008).

Figure 76

Families of CSHCN Claiming to Partner in Decision Making at All Levels and Are Satisfied With the Services They Receive, D.C. versus National, 2001 and 2006

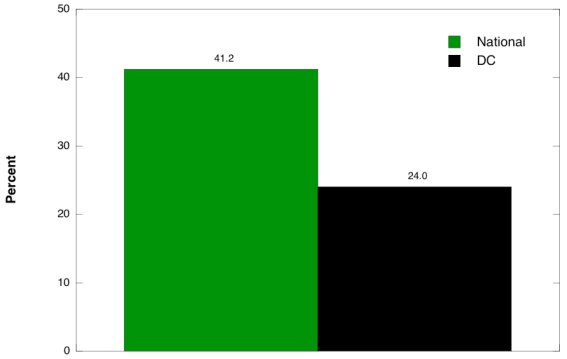


Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children with Special Health Care Needs 2008 (HRSA 2008).

The last outcome reviewed in this section measures whether youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence. Though a longitudinal perspective is not possible due to a lack of data from the 2001 study, the 2006 study does not provide encouraging data for Washington, D.C. While 41.2 percent of such youth appear to be getting the

Figure 77

Youth with Special Health Care Needs Who Receive the Services Necessary to Make Transitions to All Aspects of Adult Life, D.C. versus National, 2006



*The respondent was the parent or guardian in the household who was most knowledgeable about the health and health care of the children under18 years of age. For 78 percent of the children, the respondent was the mother. Respondents for the remaining children were fathers (16 percent) or other relatives or guardians (6 percent).

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Survey of Children with Special Health Care Needs 2008 (HRSA 2008).

services they need nationally, a mere 24.0 percent reported this to be the case in D.C. (figure 77) (HRSA 2008).

Overall, it appears that there is progress being made in some areas when it comes to health care for children with special care needs in Washington, D.C., but in other areas there are still major gaps. Recent improvement has been realized when it comes to paying for and accessing health care services for CSHCN, but this care is less likely to follow the medical home concept (HRSA 2008. Only just over half the families surveyed in the District report being partners in and feeling satisfied with the services they receive, and fewer than a quarter report receiving the services needed to transition to all aspects of adult life.

4.5. Conclusion.

There are several areas where the District is faring better on a given Title V indicator on its most recent measurement when compared to prior measurements. This was true in the case of condom use by high school students (where District students surpassed their national counterparts), alcohol use during pregnancy, perinatal mortality, school-based oral health programs, CSHCN families reporting adequate insurance, and CSHCN families reporting that community-based services were organized to be easily accessible. While there was no clear trend over time, the District also surpassed the nation in its testing children under age six for EBLL.

Title V areas that have shown improvement over time but still remain a concern because they continue to lag national performance are: low-birth-weight live births, live births to teen mothers, students engaging in recommended levels of physical activity, students carrying weapons (2007 as compared to 1993), CSHCN families reporting unmet need for specific health care services, and CSHCN families reporting that they do not have a usual source of care (or rely upon the emergency room).

Areas of greater concern in the District include: preterm births and the students consuming the recommended quantities of fruits and vegetables (2007 as compared to 1999), which have both deteriorated over time. Indicators where the District has worse measures than the nation that have not shown substantial change over time (or for which longitudinal data are not available) include: early prenatal care, student perceptions of school safety, child abuse, reported gonorrhea and chlamydia, current asthma, and CSHCN families reporting that youth receive the necessary services to adequately transition to adulthood.

The Title V indicators that have both worsened over time and were worse in the District, as of the most recent measurement, than they were in the nation are of the greatest concern. These indicators include: infant mortality, obesity among students, students involved in a physical fight over the past year, student reporting that they have ever had asthma, and CSHCN families reporting that they do not have engage in coordinated, ongoing comprehensive care in a medical home.

5. Focus Groups.

5.1. Introduction.

Organizations involved in maternal and child health in the District of Columbia were identified by the D.C. Department of Health and the consulting company, InterGroup Services. Representatives of each organization were contacted and each was asked to assist in identifying and recruiting members for a focus group made up of its clients. The focus groups were organized with the intent of soliciting feedback from the community on matters relating to MCH and getting different perspectives regarding what is and what is not working for children and families in Washington.

5.1.1. Background.

Ten focus groups were conducted throughout the District. Organizations involved were asked to develop participant lists made up of their clients, and representing each of the region's eight wards. Focus groups were easier to organize in certain wards, particularly wards 7 and 8, than in others, such as wards 2 and 3, where there is far less poverty than in some other wards and therefore little call for Title V services. Despite contacting several organizations in these wards regarding potential focus groups, only one group was developed to represent recipients of maternal and child health services in wards 2 and 3 combined. As a result, an additional focus group was organized in Ward 8. In addition to the eight community focus groups, two other groups made up of experts in the field of maternal and child health were also conducted. For a full list of agencies that partnered in the development of the Title V focus groups, please see section A.1 (located in appendix A).

The consulting firm provided a neutral facilitator at each focus group, and responses were recorded both on paper and on computer, as well as with the use of digital recorders to ensure that all answers were captured. Participants were encouraged to speak openly and honestly and were assured that their responses would remain confidential. For this reason, the results presented in the tables of this section reflect group responses, rather than individual answers. Each number in the tables that follow represents the number of focus groups that discussed a certain topic, not the number of individuals that raised a given issue.

5.1.2. Participant Demographics.

Prior to discussion, participants in the community focus groups were asked to respond to a survey that captured information regarding location of residence, race, age, marital status, family size and income, among several other questions. A total of 85 D.C. residents participated in these groups (not including the experts' focus groups, which between them included another couple of dozen people). The average age among the community groups was 35, and the plurality of residents were from Ward 4 (nearly 25 percent) and Ward 6 (approximately 18 percent). Most participants were born in D.C. (63 percent); 82 percent identified as black/African-American; and approximately 16 percent identified as being of Hispanic/Latino origin.

Survey results also showed the average household size of community focus-group participants to be four, with an average of two children per household. Approximately 82 percent of participants did not own their home and, among those who rented, nearly 28 percent received Section 8 vouchers or other rental assistance. Nevertheless, nearly 61 percent of participants reported having Internet access in their homes.

Survey questions regarding educational attainment showed that 41 percent of focus-group participants had at least a high-school degree or general educational development (GED) diploma, and 26 percent had either graduated from college or had some college experience.

Nearly 34 percent of participants in the community focus groups reported an annual household income of less than $9,999, but 6 percent claimed over $50,000 (not including the experts' focus groups).

While the great majority had health coverage (93 percent), 75 percent were insured through a public program such as the D.C. HealthCare Alliance or Medicaid. Seventy percent of participants reported being unemployed, and only 18 percent stated they were working full time (including several part-time jobs that added up to 40 hours per week).

Finally, focus group participants were asked to rate their opinions on several potential problems as they relate to the District of Columbia. They were asked to select if they "strongly agree," "agree," "disagree," or "strongly disagree" that certain issues are problems for children and families in D.C. The majority of respondents *agreed* that oral health, unintended pregnancies and teen births, access to "medical homes" for children with special health care needs, child asthma and lead poisoning were all concerns for D.C. families. The majority *strongly agreed* that poor nutrition, violence and a lack of STD screening and prevention services for teens were issues facing D.C. communities. The majority *disagreed* that infant mortality was a major problem in the District. (Infant mortality was one of the five Title V indicators, addressed in the previous chapter, that was both worse in the District over time and when compared to the nation as a whole).

5.1.3. Method.

Each of the focus groups was asked a series of nine questions regarding services that are or are not working for children and families in the District. (See section A.2 for a full list of focus group questions.) Participants were asked to respond to several questions about three subpopulations: pregnant women, mothers and infants; children and adolescents (teens); and children with special health care needs (CSHCN) and their families. Other questions were asked relating to insurance coverage, serious issues facing the community, recent changes and where members of the community go to receive services, among others.

Given that the distinction between Title V and non-Title V programs was vague for most participants, they were not restricted to speaking only about Title V-funded programs, but were encouraged to speak about all services provided for the MCH population. Services discussed ranged from medical services to transportation and education-related programs and initiatives for children and families. While participants were asked to answer some questions as they directly pertained to the three subgroups previously mentioned, many felt compelled to discuss what is and is not working specifically for men and fathers or the entire MCH population as a whole. All responses were recorded and tallied.

5.2. Findings.

Many focus group participants were active members of their communities, and the groups provided a great number of suggestions for what should be done to improve services for children and families in the D.C. area. In order to present the key results of the groups, topics mentioned in at least 2 of the 10 focus groups are presented in the tables in this section. For a complete list of responses mentioned only by a single group, please see section A.3. In the sections that follow, the discussion includes the input of the expert focus groups.

5.2.1. Best MCH Services/Initiatives in D.C.

Focus group participants felt strongly that several services and initiatives for children and families in the District were working well (table 2). Many programs for *pregnant women, mothers and infants* were discussed. Among them, the most prominent by far were the Special

Supplemental Nutrition Program for Women, Infants and Children (WIC) and the general prenatal-care services available in D.C. Specific sites mentioned as providing the best prenatal care included the Children's National Medical Center, Mary's Center for Maternal and Child Care, and the District of Columbia Birth Center, among others. Participants generally felt that prenatal care and obstetrics/gynecology services were readily available at these and other venues, and appointments were easily established even for publicly insured clients.

The Healthy Babies Project, a private, non-profit community-based organization located in Ward 6, was also frequently cited by focus-group participants as an organization providing some of the best services for pregnant women, mothers and infants in the District. Aside from prenatal care services, participants noted that the Healthy Babies Project also provided other medical, support and referral services that are highly beneficial to the community.

Among the best services/initiatives mentioned for *children and adolescents* were Covenant House, the Boys and Girls Club, the Children's National Medical Center (CNMC) and the Arc of D.C. Services at Covenant House for homeless teens, including teen mothers, were cited as being especially valuable. While participants frequently stated that there were not enough recreational activities available for D.C. youth, programs provided by the Boys and Girls Club and the Arc of D.C. were regarded as being among the best available.

Table 2

Focus Groups:

Best Services/Initiatives
(Responses raised in at least two focus groups)

Services/Initiatives	Groups
Pregnant Women, Mothers and Infants (ages birth to 3):	
WIC program	8
Prenatal care and obstetrics/gynecology services	8
Healthy Babies Project	4
Medical services (including clinics, hospitals and private physicians)	4
Pediatric and specialty care for infants	4
Programs offering supplies for infants	3
Breastfeeding centers	3
District of Columbia Birth Center	2
Healthy Start	2
Mom vans	2
Metabolic screening	2
Children and Adolescents (ages 4 to 24):	
Covenant House	3
Boys and Girls Club	3
Children's National Medical Center	3
Arc of D.C.	3
Latin American Youth Center	2
D.C. Children and Youth Investment Trust	2
Head Start	2
Sasha Bruce Youth Work	2
Washington Ballet	2
Children with Special Health Care Needs (CSHCN):	
Children's National Medical Center	4
Health Services for Children with Special Needs (HSCSN)	3
Transportation services	3
Family Voices of D.C.	2
Easter Seals	2
United Planning Organization	2
National Children's Center	2

Medical services provided by the Children's National Medical Center were cited as being the best for *children with special health care needs* and their families. CNMC's complex-care programs, designed specifically for children with special needs, were said to be among the best in the region and critical to serving this population. CNMC was also mentioned as being one of the few organizations that provides dental services specifically for CSHCN. Other best services included programs through Health Services for Children with Special Needs, specifically the year-round team sports programs designed for children with physical and behavioral disabilities, and publicly available transportation services to medical appointments for CSHCN. Health Services for

Table 3

Focus Groups:

Services/Initiatives That Are *Not* Working Well
(Responses raised in at least two focus groups)

Services/Initiatives	Groups
Pregnant Women, Mothers and Infants (ages birth to 3):	
TANF program	6
Inefficient processes for public services	5
Lack of knowledge of services and how to access care	5
Waiting lists	3
Subsidized child care	2
Children and Adolescents (ages 4 to 24):	
Lack of recreational programs for youth	5
Lack of parenting	5
School-related concerns	3
Eligibility requirements for public services	2
Misinformation or lack of information about services	2
Medicaid model	2
Child abuse and neglect (including sexual abuse)	2
Children with Special Health Care Needs (CSHCN):	
Individualized Education Programs (IEPs) and testing	6
Not being diagnosed or treated properly	5
Lack of programs and specialized schools	4
Lack of transition and other services for older CSHCN	3
Untrained staff treating CSHCN (i.e., teachers and case workers)	3
Services for families of CSHCN	2
Families can't afford services	2
Services for pregnant teens with special needs	2
Men:	
Male caregivers/fathers are excluded from Title V	6
Lack of support programs for male caregivers/fathers	4
For all Groups:	
Lack of specialty care	5
Unequal treatment of non-English speakers and Medicaid recipients in hospitals	5
Funding concerns and program cuts	4
Lack of wraparound services	4
Translation services needed in hospitals and insurance offices	4
Parenting classes and education	2
Access to public services	2
Need to engage the community	2

Children with Special Needs is a non-profit, care-management network, located in Ward 8, that coordinates health, social and education services for Supplemental Security Income (SSI) and Medicaid-eligible populations in Washington, D.C.

5.2.2. MCH Services/Initiatives that Are Not Working Well in D.C.

Focus-group participants were also asked to identify the services/initiatives that they felt were not successful for the MCH population, once again focusing on the three subpopulations (table 3). For *pregnant women, mothers and infants*, the majority of the focus groups felt that the TANF welfare program was particularly ineffective. Many said that too many D.C. residents were reliant on the program, that recipients are never held accountable for the way they use the funding received, and that those truly in need are disqualified due to overly stringent eligibility requirements. Several participants mentioned that TANF recipients often spend their money on drugs and alcohol, rather than necessities for the family. Also, several focus groups noted that the recent closings of several TANF offices in neighborhoods of great need have left many recipients with no other option but to commute long distances to other TANF offices to fill out paperwork and wait in long lines for service.

Inefficient processes were also often cited by focus group participants regarding WIC, food stamps, subsidized child care and Medicaid. Income restrictions were most often cited as a limiting factor. Many families, it was said, find it more beneficial to remain unemployed and eligible for public assistance rather than work a minimum-wage job and be ineligible based on income, yet still unable to afford to pay for needed services. Many also mentioned difficulty receiving subsidized child care services or receiving Medicaid coverage, especially for infants, due to long waiting lists for medical services and the need for a doctor's visit in order to establish eligibility.

The most common weaknesses impacting *children and adolescents*, according to the focus groups, were the lack of recreational programs for youth, lack of effective parenting and structure in the home, and matters relating to D.C. public schools. While several youth programs were mentioned in focus groups as providing great services for the community, an overall lack of affordable programs for children and teens was often mentioned. Many participants stressed the lack of safety in their communities and the need to strengthen youth activities so that D.C. children can stay off the streets, out of trouble and out of danger.

The worst programs cited for *children with special health care needs* were often school related, particularly regarding early testing and diagnosis. Participants noted that special-needs children attending public schools do not enter a special education program or receive any specialized assistance tailored to their needs until an individualized education program (IEP) is established. While this is standard procedure in many school systems around the country, the problem identified by a number of focus-group participants was that school staff do not develop IEPs fast enough, and children with special needs often spend several years in public schools before their needs are identified. Beyond this, it was said that IEPs are rarely updated once established, so the changing needs of special-needs children are rarely addressed.

Frequently discussed was the lack of attention/support provided to *male caregivers/fathers*. Many specifically found the emphasis Title V places on mothers and children to be a disservice to D.C. families, as many men are active parents, and often the sole caregivers for their children. Participants frequently said that more programs needed to be made available for fathers so that they might receive the support needed in order to effectively care for their families. Some stated that they found the language included in several federally published documents and listed on some program web sites to be offensive for fathers in the community. One participant said, "Men don't have a voice…. We're not even mentioned in the literature." Another stated that the term "families" is meant to be inclusive of both parents, but that "we need to be *more* inclusive of men in the family definition."

Focus groups also felt that there were several programs/initiatives that impacted all groups in the maternal and child health community. Among them were a perceived lack of specialty care and wraparound services, particularly for residents in need of substance-abuse and mental-health services, and what was seen to be unequal treatment of non-English speakers and Medicaid recipients in hospitals. Many participants felt that they had been unfairly treated in hospitals and ultimately received unequal care compared to the services received by other patients. The impact of the depressed economy was also frequently noted, as many programs for D.C. children and families were said to have been cut due to budget constraints. Finally, translation services were cited, specifically for the growing Spanish-speaking population in the District, as a needed service that is lacking in many area hospitals, local health centers and public-service offices. Spanish-speaking participants found it difficult to access available services and process the necessary paperwork through administrative offices (particularly for insurance and child-care vouchers) due to the inability of staff to communicate with them.

5.2.3. What Should be Done to Help the MCH Community?

The discussions that took place during the Title V focus groups resulted in a wealth of ideas regarding what should be done to help D.C. children and families in need (table 4). Specifically for pregnant women, mothers and infants, participants felt that on-site child care was among the most-needed services for families. Due to difficulties accessing affordable, quality care, families often find it difficult to work, attend school or even access medical appointments. Others felt that the strict eligibility requirements for public assistance were negatively impacting many families in D.C., especially those members who tried to work and go to school, and were ultimately

Table 4

Focus Groups:

What Should be Done to Help?
(Responses raised in at least two focus groups)

Services/Initiatives	Groups
Pregnant Women, Mothers and Infants (ages birth to 3):	
On-site child care (at school and at work)	4
Financial assessments to determine individual eligibility for public services	2
Parenting classes and continuing education	2
Children and Adolescents (ages 4 to 24):	
More programs overall	5
Changes to the school system (staff and programs)	3
More recreation centers	3
Transportation to services	3
Keep children off the streets (truancy law)	2
Children with Special Health Care Needs (CSHCN):	
Mentoring and counseling programs	6
Changes to school special education programs	3
For all Groups:	
Education regarding available services	9
Media campaigns to address stigma and misinformation	4
Establishment of trust in the government, medical professionals and school staff	4

penalized due to income restrictions. As a result, some participants suggested that individualized financial assessments would be the most effective means for the District to establish more appropriate income limits based on each family's financial situation.

For children and adolescents, participants often identified the need for more programs for youth, particularly recreation and after-school programs that keep children off the streets and out of trouble. Many also felt strongly about the D.C. public school system and the need for substantive change in order for D.C. youth to receive an adequate education and have the ability to transition into the workforce. Suggestions included hiring new, culturally sensitive staff, and implementing new training programs for current staff to teach them how to appropriately address certain behaviors (such as being disruptive in class), among other suggestions.

Changes to the current school system, specifically special-education programs, were cited as a way to help children with special needs in D.C. As previously discussed, the late establishment of IEPs, in particular, was seen as a concern. Many cited inadequate school programs as making it impossible for CSHCN to transition to adult life and establish independence from their families. The top suggestion to remedy the situation was that more mentoring and counseling programs be established. This suggestion referred not only to children with learning and physical disabilities, but also to those struggling with behavioral problems that limit their ability to learn in an average school setting.

Finally, focus group participants stated that the most important thing that should be done to help all maternal and child health groups is to improve the availability and dissemination of information regarding available services, including how to access affordable care. In many cases, it was said, families do not receive the services they need because they do not know about them, or they simply do not know how to access them. Suggestions for getting this information out included the publication of a free, printed service directory that would be available at health centers, libraries, and near public transportation access areas. Media campaigns were also noted as a way to effectively advertise to the public. Participants suggested that not only should media campaigns be used to make families aware of available services, but they should be used to eliminate stigma regarding STDs and other issues that are often misunderstood by the community, especially youth.

5.2.4. Do Families Have Adequate Insurance?

Participants from all of the focus groups stated that D.C. families do not have adequate insurance to pay for the services they need (table 5). While many felt that D.C. Medicaid was relatively easy to access, and that few applicants were denied, it was clearly felt that *all* necessary services were not covered; therefore families either are forced to do without or they struggle to pay for needed services out of pocket.

Table 5

Focus Groups:

Do Families Have Adequate Insurance?
(Responses raised in at least two focus groups)

Response	Groups
No, all necessary services are not covered	10
What barriers do they face?	
Reimbursement issues affecting care	8
Misinformation regarding coverage	6
Not eligible for Medicaid and can't afford private insurance	4
Few Medicaid accepting physicians	2
Cost of coverage	2
Not eligible due to pre-existing conditions (specifically for CSHCN)	2

The Medicaid model was mentioned, especially during the expert focus groups, as an ineffective way to provide health coverage to the public due to the tendency to focus only on covered health issues, rather than all health concerns (such as health education to reduce high-risk behavior or therapy for special-needs children). Similarly, misinformation regarding services that are and are not covered under Medicaid was often noted by group participants. Many cited instances when they did not access a specific service because someone had relayed the incorrect information to them regarding coverage.

Eligibility requirements, specifically income restrictions, were also noted as a common reason why D.C. families were unable to access health coverage. Several participants stated that even though their present employers did not provide health insurance, income restrictions still left them ineligible for Medicaid. The only option, according to participants, was individually purchased private insurance, which many stated was simply not affordable. The lack of Medicaid-accepting physicians was also mentioned in several groups as a barrier to care for D.C. families, as many doctors refuse to see patients covered under Medicaid because of the slow reimbursement process. Finally, the difficulty that families with children with special health care needs face when trying to obtain adequate health coverage was noted as a key barrier. Many insurance companies consider a child's disability to be a pre-existing condition and thus refuse coverage. This results in either the inability of families to obtain coverage for their special needs children, or the financial strains of having to pay significantly higher premiums for health insurance.

5.2.5. Other MCH Problems, Concerns and Serious Issues Impacting Communities.

When asked what other serious issues were impacting children and families in D.C., focus-group participants provided a wide range of responses (table 6). All of the groups stated that domestic violence and sexual abuse were problems throughout the District. Other top issues included drug use (including parents using drugs in front of or with their children), the lack of sex education in schools, and unsafe communities due to a variety of issues, including gang-related violence. Members of the community generally felt that the overall lack of affordable youth programs, poor parenting skills and trouble in the home (divorce, domestic violence, etc.) were resulting in other serious problems, such as drug use and teen pregnancy.

Table 6

Focus Groups:

Other Issues Impacting Families
(Responses raised in at least two focus groups)

Response	Groups
Domestic violence and sexual abuse	10
Drug use	7
Lack of sex education	7
Unsafe communities	6
Lack of effective parenting	5
Few affordable youth programs	5
Teen pregnancy	4
Education system	4
Few programs for single fathers	4
Access to dental care	4
Promiscuity and birth control use	3
Stigma regarding STDs and testing	3
Obesity	3
Lead poisoning	3
Problems in the home	2
Court system and child protective services	2
Police brutality	2
Violence	2
Few career development/employment services	2
Asthma	2
Lack of affordable housing	2

Table 7

Focus Groups:

Recent Changes Impacting Children and Families
(Responses raised in at least two focus groups)

Topics	Groups
Program closures due to budget constraints	5
Decreased religion and church involvement	4
Drug use	3
Violence	3
Community morale/concerned citizens	3
Family dynamics/structure	2

Access to care, particularly dental care, remains a concern for D.C. families. Focus group participants noted that there are very few Medicaid-accepting dentists available, and the waiting lists for routine care are extremely long. Most dentists only accept private health insurance, which many residents do not have, and/or do not accept uninsured patients at all.

Issues related to sexual behavior and promiscuity were frequently discussed in the groups, particularly as they relate to unintended pregnancies and STDs. Participants stated that many members of the community frequently engage in unprotected sex, and many openly admit to not getting routinely tested because they would "rather not know" the results.

5.2.6. Recent Changes Impacting MCH in D.C.

Focus groups were asked to cite recent changes, both positive and negative, impacting children and families in the District (table 7). Unfortunately, the most commonly discussed changes were negative, and included program closures due to budget constraints, lack of church involvement in the community, drug use, violence, a decrease in community morale and an overall lack of concern for the community, and finally, a lack of structure in the family that is leaving youth to care for themselves, which too often leads to poor decision making.

It was felt that the first programs or offices to close due to budget constraints are those in the outlying communities, such as wards 7 and 8, where the greatest need exists and where transportation continues to be a barrier. Participants from Ward 8 also felt that youth were increasingly separating themselves from the church, and that many are changing religious affiliation, converting to Islam. Some felt that this was simply a way for youth to express themselves; others felt that the rise in Islamic affiliation among D.C. youth is entirely attributable to the fact that D.C. public schools allow students to leave school on certain days to attend mosque.

While drug use and violence were explained to be ever-present issues in the District, participants felt that these issues were getting worse. Participants felt that certain drugs, such as marijuana and

alcohol, have become mainstream, and that youth do not see the harm in using them. Many said that often there are people smoking and drinking in the streets, exposing young children to drug use, and facing little to no consequences for their actions due to the lack of police authority in many neighborhoods.

5.2.7. Where Do Families Go to Receive MCH Services?

According to focus group participants, neighborhood clinics/area health centers are the most common places that children and families in D.C. receive needed services (table 8). These organizations were noted to be easily accessible and a guaranteed location where publicly insured or uninsured families can receive care. Nevertheless, long wait times were mentioned in 4 of the 10 focus groups as a key struggle for patients at local area clinics. The Children's National Medical Center was the second-most-common response to this question due to its range of services, acceptance of Medicaid-insured patients, and specialized programs for children with special needs.

The Edgewood/Brookland Family Support Collaborative, a community-based organization serving wards 5 and 6, and one of seven neighborhood-based organizations that make up the Healthy Families, Thriving Communities Collaborative, was often cited as a place where families in D.C. commonly go to receive services. Similarly, the UPO/Ralph Waldo "Petey" Greene Community Service Center, a community organization striving to strengthen families in wards 7 and 8, was also frequently mentioned. Participants emphasized the ability of grassroots organizations such as these to more effectively identify the needs of the community and the most culturally sensitive approaches to solving problems. Additionally, members of the community claimed that they felt more comfortable going to community organizations for help rather than more formal public health centers or doctors' offices.

Again, waiting lists, ineffective processes, strict eligibility requirements and a lack of knowledge regarding available services were the most common obstacles noted by focus group participants regarding accessing needed services. Lack of care coordination was also noted as a common obstacle for families, as needed services are rarely co-located, yet service providers struggle to communicate with one another to monitor all the levels of care received. Inability to afford needed services, due to lack of insurance or lack of coverage for a specific service, was also cited as a barrier. Finally, geographic distribution was discussed as a significant obstacle for families trying to receive services in D.C. because providers are rarely located in the areas of greatest need, and many families struggle with transportation.

Table 8

Focus Groups:

Where Do Children and Families Receive Needed Services?
(Responses raised in at least two focus groups)

Location	Groups
Neighborhood clinics/area health centers	6
Children's National Medical Center	4
Community organizations	3
Workforce development centers	3
Healthy Babies Project	2
School health centers	2
What obstacles do they encounter?	
Waiting lists	4
Ineffective processes and strict eligibility requirements	4
Lack of knowledge regarding available services	4
Lack of care coordination	2
Poverty (cannot afford services)	2
Geographic distribution of services	2

5.2.8. Other Topics of Concern.

Finally, before concluding each group, participants were given the opportunity to voice their thoughts regarding any other topics of concern. As seen in table 9, many issues were raised, including several that had been previously

Table 9

Focus Groups:

Other Topics of Concern
(Responses raised in at least two focus groups)

Topic	Groups
School-related issues	7
Affordable housing	5
"I don't care" mindset	4
Unsafe environments	4
Adult education	3
Abuse of the system/government handouts	3
Services for incarcerated and their families	3
STDs/STIs	3
Federal funding	3
Child Protective Services	2
Transportation	2
Child care	2
Court system	2
Sex education	2
Screening and early intervention services	2
Asthma	2

discussed. Top concerns included matters relating to the quality of the D.C. public school system, lack of affordable housing, the "I don't care" mindset that many have adopted regarding the status of their health and the need for STD testing, and an overall lack of safety in many neighborhoods.

Others expressed concern over the lack of adult education, especially in reference to family planning, sexually transmitted diseases and parenting skills. Many felt that parents often are not taught how to appropriately care for their children, as well as themselves, and that education services would go a long way.

Consistently voiced throughout the focus groups was the belief that public programs, particularly the TANF program, need to be significantly restructured so that children and families in the District will benefit more from them. Participants expressed the opinion that funding needs to be monitored to ensure that it is going toward needed services for the family (rather than drugs or alcohol), that TANF needs to be enforced as a *temporary* assistance program, and that parents need to be encouraged to provide for their families on their own rather than always relying on public assistance.

5.3. Limitations of Focus Groups.

While there is a great deal to be learned by conducting focus groups, this method of research also presents several limitations. First, the small sample size (85 community and 22 expert participants) is not fully representative of the MCH population in the District of Columbia. In all focus groups, topics discussed — at least those discussed in any detail — can relate only to the experiences of focus-group participants, their families and friends, or relate entirely to the work being conducted by a particular participant or group. As a result, the topics addressed in each focus group may not encompass all of the issues impacting the MCH population.

According to the article, "How Focus Groups Work," by Jody Temkin, respondents may feel pressure to give answers they think will please the moderator or they may simply agree with what other participants are saying. This, coupled with the facilitator's way of phrasing questions and the environment where the focus group takes place, can also affect responses and skew results (Temkin 2010).

Another limitation is the possibility of "group think," whereby a few individuals dominate the group's discussion and others feel pressured into agreeing with what is being said, or simply hold back from expressing their own view in light of what others may think (FE 2010). InterGroup Services, the consulting company, attempted at all time to minimize these tendencies (e.g., by using moderators of the same ethnic background as the majority of the participants), but nonetheless the above are all limitations to consider when assessing the validity of focus group results.

5.4. Conclusions.

As with all focus groups, the participants in these gave a wide range of answers. However, certain themes did surface repeatedly and these are summarized here. In terms of what is working best for pregnant women, mothers and infants, the most popular responses by far were the WIC program and prenatal care and obstetrics/gynecology services in D.C. For children and adolescents, the most frequently mentioned programs were Covenant House, the Boys and Girls Club, the Arc of D.C. and the Children's National Medical Center. The latter was also the most popular with regard to CSHCN.

As for what was considered to be not working well, the TANF program was very unpopular when discussing services for pregnant women, mothers and infants. When the topic turned to children and adolescents, while no particular program was mentioned multiple times, the lack of recreational activities and the perceived lack of parenting skills among young parents were frequently noted. For CSHCN, IEPs as administered by the D.C. public school system were commonly stated to be inadequate, and respondents complained too that children's special needs were often misdiagnosed or mistreated.

6. Key Informant Interviews.

6.1. Introduction.

Experts in maternal and child health in Washington were identified by the District of Columbia Department of Health and interviewed by InterGroup Services, the consulting company hired to conduct the 2010 Title V needs assessment. The questions asked in the key-informant interviews had been previously devised by DOH and IGS personnel. The interviewees represented large national organizations and hospitals as well as small grassroots organizations.

6.1.1. Background.

A total of 11 experts were selected by the DOH for interviews based on their expertise, and, in several cases, former relationships through grant applications with the Department of Health's Community Health Administration. Two of those selected were unable to participate and were replaced with other experts working in the field of maternal and child health in the District. For the purposes of confidentiality, only the interviewees' organizational affiliations are provided in this document. (See section B.1 located in appendix B for a list of organizations.)

6.1.2. Objectives.

The goal of the key-informant interviews was to learn what is and is not working well for the MCH population in D.C. from a provider perspective, and to find out what providers recommend be done to solve these problems. The IGS interviewer at no time prompted the interviewees' answers. This summary reports interviewees' answers as given.

6.1.3. Method.

Phone interviews were conducted during October and November 2009. Interviews ranged from 45 minutes to 2 hours, depending on the length of the interviewees' responses. Two of the interviewees were presented with additional questions pertaining specifically to children with special health care needs, as they were experts of the needs of that specific population. The questions are reproduced in section B.2.

For most interviewees, eight questions were asked. Areas of discussion included:

- Services/initiatives that are and are not working well for pregnant women, mothers, infants, children, children with special health care needs, and adolescents in D.C.
- Biggest challenges.
- Other unmet needs.
- Recommendations for improvement.
- Outcome performance measures.
- Agency collaborations, including strengths, weaknesses and recommendations for improvement.

6.2. Findings.

The 11 key informant interviews produced a wealth of responses. Below, the results have been tabulated for each of the questions asked. Topics receiving two or more mentions have been put into tables in order to highlight the most common responses for each of the interview questions (and questions receiving only one mention may be reviewed in section B.3).

Questions that required the interviewee to address specific subpopulations resulted in a varying number of responses for each subgroup — pregnant women, mothers, infants (birth to age 3);

Table 10

Key Informant Interviews:

Services/Initiatives that are Working Well
(Issues raised by at least two key informants)

Services/Initiatives	Number
For Pregnant Women:	
Developing Families Center (Healthy Babies Project)	3
WIC Program	3
Mobile vans (screening)	2
Mary's Center Home Visiting Program	2
Prenatal care (access to and quality of)	2
For Mothers:	
WIC Program	5
Mary's Center Home Visiting Program	3
Healthy Babies Project	3
Links to employment	2
Referrals for other services	2
Case-management services	2
Parent resource centers	2
Healthy Start	2
For Infants (ages birth to 3):	
WIC Program	5
Pediatric care (access to and quality of)	3
Healthy Babies Project	2
Health insurance coverage through Medicaid MCOs	2
Safe Cribs program	2
Children's National Medical Center (CNMC)	2
Child care vouchers	2
Early intervention services (identifying delays)	2
For Children (ages 4 to 12):	
Immunization campaigns	3
Pediatric care (access to and quality of)	2
SCHIP insurance program	2
Head Start	2
Early Stages program (Edgewood-Brookland Family Support Collaborative)	2
For Children with Special Health Care Needs (CSHCN):	
Health Services for Children with Special Needs, Inc.	2
CNMC – for both pediatric and specialty care	2
Healthy Schools Network, Inc. (HSN)	2
Screening for developmental delays	2
For Adolescents (ages 13 to 24):	
After-school/recreational programs	2
Mary's Center programs for adolescents	2
Latin American Youth Center	2

children (ages 4 to 12); children with special health care needs and their families; and adolescents (ages 13 to 24). For each subgroup, only those issues raised by two or more informants are included. Responses mentioned only once are not included in the tabulation because they did not attain a sufficient level of significance to merit inclusion; they are, however, listed in section B.3. For some groups, particularly adolescents, there were very few commonalities among the responses.

6.2.1. Services that Are Working Well. Respondents were first asked what services and initiatives are working well for recipients of maternal and child health services in Washington (table 10). For pregnant women, the most common answers were the D.C. Developing Families Center of the Healthy Babies Project and WIC. WIC was also cited as a best service for mothers, in addition to the Mary's Center Home Visiting Program and services provided by the Healthy Babies Project. WIC was also mentioned as the best service for infants in D.C., in addition to general pediatric care throughout the area, including access to care and the quality of care received.

While several services were mentioned, "immunization campaigns" was the most common response for children overall. In contrast, responses for best services for children with special health care needs and for adolescents yielded few common responses. Having said this, health care at the Children's National Medical Center and advocacy work through Health Services for Children with Special Needs, Inc., are two examples of services that were said to be working well for CSHCN. Recreational programs, including those offered at Mary's Center and the Latin American Youth Center, among several other organizations, were the most common services mentioned for adolescents.

6.2.2. Services that Are Not Working Well.

Key informants were also asked to respond to services that are *not* working well for populations receiving maternal and child health services (table 11). Lack of follow up and/or support were the most commonly cited not-working-well issues for pregnant women. The lack of mental-health and substance-abuse services for both pregnant women and mothers was also discussed. No single service or initiative received multiple mentions for not working well for infants, indicating a general sense of satisfaction with services available for this population in D.C.

Table 11

Key Informant Interviews:

Services/Initiatives that are *Not* Working Well
(Issues raised by at least two key informants)

Services/Initiatives	No.
For Pregnant Women:	
Lack of follow-up and support	3
Waiting lists (for housing and medical services)	2
Lack of mental health and substance-abuse services	2
Transitional housing (access to and affordability of)	2
D.C. Department of Health (said to have inefficient processes and bureaucracy)	2
For Mothers:	
Education around family planning and parenting skills	2
Mental health and substance abuse services	2
Lack of support for organizations providing MCH services	2
For Infants (Birth to Age 3):	
No service/initiative received multiple votes	
For Children (Ages 4 to 12):	
D.C. public schools (said to have poor quality of education, lack of good teachers and safety in schools)	2
Competition for funding impacting services for children — lack of coordinated effort	2
School-based health care	2
For Children with Special Health Care Needs (CSHCN):	
Lack of quality health care for CSHCN	2
Services for CSHCN in public schools	2
Existing programs for CSHCN are strained (need more facilities and specialists)	2
For Adolescents (Ages 13 to 24):	
Lack of sex education	2
Lack of mentoring programs	2
D.C. public schools (said to have poor quality of education, lack of good teachers and safety in schools)	2

Though it is not a Title V service, dissatisfaction with D.C. public schools was a common response for children, children with special health care needs, and adolescents. The reasons offered for this response included a lack of safety in schools, displeasure with the quality of education provided to students (including services available for CSHCN), the inability to identify developmental delays in young children before it is too late, and the lack of sex education, among several other topics.

6.2.3. Biggest Challenges.

In certain instances, responses for the biggest challenges for each population replicated the responses received regarding services that are not working in D.C. (table 12); in others, however, new topics were addressed. Respondents generally found it easiest to discuss challenges for pregnant women and mothers. The most common responses included a lack of education and information about parenting and accessing care, the ability to access care (especially prenatal care), access to affordable housing and instances of domestic violence. The most common challenge reported for infants, "waiting lists for services," was also cited for pregnant women and mothers, and CSHCN, indicating a possible need for more service providers that accept publicly insured, low-income clients in the District.

The lack of early developmental-delay identification by D.C. public schools, including the development of IEPs, was cited as the biggest challenge for children, while the lack of a comprehensive medical home was most commonly discussed for CSHCN. Participation in high-risk behaviors was the most common response for adolescents, and was the only response for this

group that was raised at least twice. Several interviewees also said that funding for MCH services impacted all of the groups addressed in a negative way due to both a general lack of funding for these types of services and the competition for funding among agencies, which results in little cooperation and the tendency for providers to resist referring clients to their competitors.

Table 12

Key Informant Interviews:

Biggest Challenges
(Issues raised by at least two key informants)

Challenges	Number
For Pregnant Women and Mothers:	
Lack of education/information about parenting, accessing care, etc.	5
Accessing care, especially prenatal care	4
Housing (accessibility and cost)	3
Domestic violence and substance abuse	3
Meeting nutritional needs of themselves and their families	2
Waiting lists for services	2
For Infants (birth to age 3):	
Waiting lists for services	3
Lack of information for parents	2
Lack of early diagnosis and treatment	2
For Children (ages 4 to 12):	
Early identification of delays in D.C. public schools	4
Poverty	2
Support for parents so they can care for their children	2
For Children with Special Health Care Needs (CSHCN):	
Lack of a comprehensive medical home	3
Few providers for low-income adolescents with special health care needs – especially therapists	2
Waiting lists for services	2
Need for expansion of existing services to meet the need	2
Lack of adequate insurance for all of their needs	2
For Adolescents (ages 13 to 24):	
High-risk behaviors	2
Overall challenges:	
Private programs struggling for funding	3

6.2.4. Other Unmet Needs.

When asked what other unmet needs the community is facing, low health literacy and/or a lack of sex education, and instances of violence in the community (both gang-related and domestic violence) were the most common responses provided by key informants (table 13). Difficulty accessing care and mental health/substance-abuse issues were also common responses.

6.2.5. Recommendations for Improvement.

After identifying what services are not working well, what the biggest challenges are and other unmet needs of the community, respondents were asked what should be done to address these gaps and/or needs (table 14). A general restructuring of public organizations involved in maternal and child health services was the most common response, in addition to encouraging community involvement and dialogue to find out what the actual needs are.

6.2.6. Outcome Indicators.

When asked how their respective organizations monitor progress of their MCH programs, nearly all interviewees cited the use of an in-house database identifying the needs of their own clients and monitoring their progress (table 15). Many organizations also conduct needs assessments through the use of surveys and solicit input through interviews and focus groups regarding the quality of services they provide. While some organizations also solicit outside data for indicator analysis, most stated that they prefer to use data generated in house from their own clients' experiences to monitor how they are performing.

6.2.7. Organizational Partnering.

There was general agreement among interviewees that there is a need for greater collaboration between agencies in order to provide the best possible services to the MCH population. Several respondents shared the opinion that larger, public agencies would be well served by partnering with smaller community organizations that they feel better understand the populations in question and have better access to those populations. Often, low-income or non-English-speaking

populations, it was said, do not feel comfortable with larger organizations, and it is important for clients to feel welcome in order for them to adhere to treatment and to come to appointments.

Table 13

Key Informant Interviews:

Other Unmet Needs
(Issues raised by at least two key informants)

Unmet Needs	Number
Low health literacy/lack of sex education	7
Violence (gang-related and domestic) — being exposed to and/or a victim of violence	5
Accessing care, including emergency services	4
Mental health and substance-abuse services	3
Asthma	3
Linguistic competencies and literacy levels/education levels impacting access to care	3
Oral health care — quality and availability of existing programs	3
Funding Issues — both a lack of funding for agencies providing MCH services and competition for funding impacting the quality of care provided	2
Lack of affordable and/or accessible transportation — especially for CSHCN	2
Lead poisoning — instances of EBLLs and the city's lack of response to cases	2
STDs and HIV/AIDS	2

Table 14

Key Informant Interviews:

What Should be Done to Address These Gaps and/or Needs?
(Issues raised by at least two key informants)

Recommendation	Number
Restructure the D.C. Department of Health and eliminate ineffective processes and bureaucracy	4
Involve the community and encourage dialogue	4
Only fund quality programs, and replicate ones that have proven to be successful	3
Offer more education including sex education and parenting classes	3
Offer affordable, quality child care.	2
Offer more mental health and case-management services in D.C. public schools	2
Solicit new funding streams.	2
Offer affordable housing with priority lists for high-risk groups (i.e., pregnant teens, mothers with substance-abuse history, etc.)	2
Provide training for school nurses and other professionals about how to make referrals for CSHCN and the services that are available	2
Develop more transition projects for CSHCN, including transition resource centers	2

Some agencies, such as Mary's Center, report greater current collaboration than others, but it takes a great deal of effort. Constant communication and clear goals and objectives are required for the collaborations to be successful. However, the results can be worth it. As one interviewee expressed, collaborating with minority-specific groups such as Mary's Center can improve the cultural competency of other agencies to the benefit of D.C.'s immigrant populations.

One of the biggest obstacles to greater collaboration seems to be the pursuit of government grants. Competition for funding may lead organizations to be somewhat "territorial" about their clients, which may in turn impede the creation of effective partnerships.

Another challenge raised was the perceived high rate of turnover at public agencies like the Department of Health. Interviewees said they often find it difficult to get in touch with the right person because people tend to move on so quickly. Elimination of bureaucracy at the Department of Health, it was said, would also make collaborations easier.

6.3. Conclusion.

With respect to what is working well in the District, the findings from the key informant interviews largely echoed those of the focus groups. WIC, the Healthy Babies Project, access to and quality of prenatal care, Healthy Start, the Children's National Medical Center, Head Start, Health Services for Children with Special Needs, and the Latin American Youth Center were each mentioned by multiple focus groups and by multiple key informant interviewees. Waiting lists, services for CSHCN in public schools, and D.C. public schools for all children were noted as areas that were not working

Table 15

Key Informant Interviews:

How Does Your Organization Monitor Progress?
(Issues raised by at least two key informants)

Outcome Indicators	Number
In-house database — identify the needs of their own clients and monitor progress	10
Needs assessments using surveys, interviews and focus groups	8
Soliciting external data for analysis	5
Collaboration with other organizations	4
Federal regulations for transition programs, national recommended methods	4
Day-to-day calls/complaints	3

well by multiple focus groups and key-informant interviewees.

Even as multiple key informants noted prenatal care as an area that is going well in the district, multiple interviewees also pointed to this area as one of the biggest challenges. Low health literacy/lack of sex education, violence, and access to care were the most frequently cited areas of unmet need by key informants. Interviewees most often suggested restructuring the D.C. Department of Health to eliminate ineffective processes and bureaucracy, involving the community and encouraging dialogue, and only funding quality programs as means of addressing service gaps and needs in Washington, D.C.

7. D.C. Maternal and Child Health Community Forum.

7.1. Introduction.

The D.C. Maternal and Child Health Community Forum was held at the Charles Sumner School in Washington, D.C., on April 6, 2010. A total of 51 professionals and members of the community attended the forum, 10 representing the Washington D.C. Department of Health, and others representing local agencies involved in the provision of maternal- and child-health services in the District. The purpose of the meeting was to provide maternal and child health stakeholders and District residents with the opportunity to make recommendations to the Department of Health regarding what issues they felt deserved to be labeled Title V priorities for the upcoming five years.

Prior to the meeting, attendees who pre-registered were provided with a document prepared by the D.C. Department of Health's Community Health Administration, in collaboration with the consulting firm, IGS, that summarized the findings of the needs assessment. Additional copies of the document were distributed to attendees upon their arrival, along with priority-ranking materials and copies of the afternoon's presentations.

7.2. Presentations.

The forum commenced with a brief overview and explanation of the Title V program by Dr. Anjali Talwalkar, deputy director for public policy and programs and Title V director for the Department of Health's Community Health Administration. The presentation included an overview of Title V goals for maternal and child health, reviewed the District's 2005 Title V priorities, and stressed the importance of the community forum in helping to inform the department of how the community feels are the best ways to use its Title V resources.

Following Dr. Talwalkar's presentation, Dr. Douglas Munro, president of IGS, explained the processes involved in conducting the 2010 Title V needs assessment, as well as the results of the needs assessment thus far. These results included a synopsis of the indicator data that had been collected, as well as summaries of focus groups and key-informant interviews, the results of which impacted a portion of the indicators chosen. Throughout the presentation, attendees were given the opportunity to ask questions and make comments about the research process.

7.3. Breakout Sessions.

Following the data presentation, forum participants were asked to break into smaller groups in order to begin a more in-depth discussion of priorities for the three subpopulations of the maternal and child health community: pregnant women, mothers and infants (birth to age 3); children and adolescents (ages 4 to 24); and children with special health care needs (birth to age 24). Each group met for approximately 30 minutes to discuss the data presented by Munro. Participants discussed their agreement and disagreement with many of the indicator findings from the needs assessment process, and were given the opportunity to discuss additional priorities that they felt were important for the Department of Health to consider in the coming years.

7.3.1. Pregnant Women, Mothers and Infants Group.

Participants of the breakout session focusing on priorities for pregnant women, mothers and infants largely agreed with the results of the key-informant interviews and focus groups regarding priorities for this subpopulation, but also thought that there was a great deal to be added. Some of the topics of greatest importance to this group included:

- Reinstating follow-up programs that are no longer funded.

- Increasing program evaluation, monitoring and surveillance of services for this subpopulation to ensure that the best services continue to be funded.
- The importance of dealing with *all* social issues impacting pregnant women, mothers and infants, including the provision of affordable, stable housing, finding employment, and the treatment of co-morbidities such as substance abuse and mental-health disorders.
- Increasing the number of programs that teach parenting skills and ensuring access to them.
- Increasing knowledge about available services through the dissemination of information to clients, and the posting of user-friendly information on web sites.
- Increasing breastfeeding awareness and education in hospitals.
- Decreasing unwanted pregnancies by speaking with new mothers in hospitals about ways to prevent a second pregnancy and offering contraception.
- Restructuring the prenatal care model to include a group approach.

When asked to identify the top priorities for pregnant women, mothers and infants, participants identified the following:

- Decreasing infant mortality.
- Increasing the availability of and access to insured prenatal care services.
- Increasing access to family planning services.
- Encouraging women to be self-advocates and teaching them the appropriate questions to ask of their doctors.
- Increasing agency collaboration/coordination and the sharing of information among providers of maternal and child health services.
- Strengthening the relationship between D.C. public schools and the Department of Health to ensure that teen mothers return to school after giving birth.

Participants were asked to also consider ways DOH could target these priorities. The most common responses were restructuring the insurance-eligibility process so that women can get insurance and gain access to care as soon as possible, developing programs in hospitals to educate women about how to prevent unwanted pregnancies, and continuing media efforts regarding available services so that people know where to go to receive care.

Lastly, the recent development of a new Department of Health initiative that involves the use of a "global assessment form" was discussed. This form will be used by managed-care organizations (MCOs) to identify risks among clients and facilitate referrals as quickly and as easily as possible so that clients can get all of the care they need in a timely manner. Participants were pleased to hear of this initiative and appreciated the benefits their clients would receive from these efforts.

7.3.2. Children and Adolescents Group.

The group focusing specifically on children and adolescents had many suggestions regarding the top priorities for this subpopulation. Some of the topics discussed included:

- The connection between good parenting and success in schools.
- The lack of emphasis on nutrition in schools.
- Early identification of disabilities (both mental and behavioral) in schools.

- The need for more coordination between the D.C. Department of Health and D.C. public schools.
- The need for greater coordination among existing programs for children and adolescents.
- The development of standards of service to guide providers.
- The need for more community child-care centers.
- Decreasing teen pregnancy and infant mortality.
- Increasing sex education in schools.
- The development of more community organizations (i.e., neighborhood collaborative organizations).
- The restructuring of the Department of Health's web site so that it is user-friendly and the community can utilize it as a resource for information.

This group felt that the top priorities for children and adolescents were:

- Decreasing teen pregnancy.
- Decreasing the rate of sexually transmitted diseases/infections among youth.
- Developing a set of standards for organizations providing services for children and adolescents, rather than just providing guidelines.
- Increasing funding for school health centers, and developing new centers where possible.
- Increasing sex education in schools, especially regarding STD and pregnancy prevention.
- Increasing literacy programs.
- Providing material about program availability and eligibility requirements on line, where it can be easily accessed and updated frequently (agency web sites).

When asked what the department could do to emphasize these priorities, participants noted that child-care centers are currently receiving grants to provide training and other programs, and this should continue. Participants also stated that initiatives to disseminate sex education materials should continue, and that sex education curriculums in schools should be strengthened and further emphasized.

7.3.3. Children with Special Health Care Needs (CSHCN) Group.

As with the other groups, the CSHCN group agreed in large part with the results from the key-informant interviews and focus groups that were conducted regarding priorities for CSHCN. In addition, they felt that several other topics were also of great importance to this subpopulation, including:

- The general lack of quality care (also said to be a problem nationwide).
- The lack of quality early intervention services.
- The shortage of providers who specialize in CSHCN.
- The need to inform families of CSHCN about available services and programs, as well as how to properly care for their child based on their particular needs.
- Insurance caps on services resulting in barriers to care.
- The lack of services to help CSHCN transition into adult life.

- The lack of pediatric palliative care services.
- The perceived lack of commitment among those working with CSHCN.
- The lack of focus on issues relating to sexuality for CSHCN, both in training for providers and education for the children.
- The difficulty of developing long-term approaches to solving problems for CSHCN as a result of high staff turnover within the Department of Health.
- Lack of long-term approaches to solving problems for CSHCN overall.

When asked what the Department of Health should do to focus on these priorities, participants had several suggestions, as follows:

- Educating providers about available programs and services.
- Increasing promotion of available programs and/or resources.
- Increasing the availability of better-trained nurses in the District.
- Increasing recreational services for CSHCN to help fight obesity and improve nutrition.
- Improving coordination of services within the Department of Health.
- Providing funding waivers for things not covered by insurance.
- Increasing the emphasis on coordination of services.

At the conclusion of the session, participants representing the Department of Health expressed their concern that stakeholders in the District have traditionally measured progress based on the acceptance of ideas submitted to the department, and feel that it is a failure when ideas are not followed through upon. CHA Deputy Director LaQuandra Nesbitt noted, "We [CHA] care about all of these issues, but the pie is finite, so we have to prioritize...." She continued by explaining that greater collaboration needs to be achieved between the Department of Health and the community so that ideas can be realized; she stressed the department's desire to receive feedback from stakeholders on how to better serve them or assist them in the preparation of their submissions. Finally, CHA staff questioned whether the processes already in place are being fully utilized by stakeholders to develop proposals and effectively communicate ideas for programs and services to the department. They thought that ensuring use of existing mechanisms would be the best place to begin in determining what needs to be done to improve the working relationship between the Department of Health and community stakeholders.

7.4. Recommendations.

Following the breakout sessions, a brief summary of each session was delivered by IGS staff, followed by a final opportunity for attendees to ask questions prior to making their priority recommendations.

Forum participants were given the opportunity to make informed recommendations to the D.C. Department of Health regarding where they should direct their focus over the next five years. They were asked to consider the quantitative and qualitative information that had previously been provided by IGS when making their decisions, as well as their own personal experiences as both members of the community and/or professionals in the field of maternal and child health. Each participant selected what he or she felt should be the top five priorities, giving 10 points to each top priority, 8 points to each second priority, etc. Each priority could be selected from a list of pre-printed issue areas on stickers given to each participant, or stakeholder preferences could be

written in.[7] Table 16 provides the final, tabulated recommendations for the D.C. Department of Health as a result of the voting exercise.

As is evident in table 16, reducing unintended pregnancies and teen births was the top recommendation made by forum attendees, garnering 98 total points, followed by decreasing infant mortality (88 points), and increasing community knowledge of available services and improving diagnosis of health care needs in schools (76 points each). Among topics that were written in by attendees, the most popular recommendations were increasing home visiting programs for mothers (48 points), increasing access to mental health services (32 points), and increasing agency collaboration and coordination (30 points).

The top five priority recommendations proved to be a reflection of the 2005 Title V priorities, demonstrating the continued importance of these issues for the maternal and child health community in Washington, D.C. In addition to these recommendations were an array of write-in responses that confirmed the range of concerns for this population, as well as the dedication of professionals in the field of maternal and child health.

Nearly all of the priority recommendations that were made mirrored the quantitative and qualitative data that were presented to forum participants. Analysis of the Title V indicators proved the need to focus on teen pregnancy, infant mortality, sex education in schools, access to medical services, and education regarding nutrition and physical activity for youth. These topics were judged to be of most importance during the prioritization exercise. All of the indicators discussed from the data analysis were found to be of importance in the prioritization exercise.

In terms of qualitative data, some of the most predominant concerns of focus group and key informant interview participants were that lack of knowledge regarding available services, special health care needs diagnosis in schools, and an overall lack of health insurance coverage, adequate child care and recreational programs for youth. All of these topics were ranked in the prioritization exercise as well, once again substantiating the Title V data that had been analyzed.

7.5. Conclusions.

The D.C. Maternal and Child Health Community Forum provided the opportunity for members of the community and professionals involved in maternal and child health services to become aware of the results of the Title V needs assessment process, and make informed recommendations to the D.C. Department of Health regarding what they felt should be the top priorities over the next five years in the District of Columbia. The lively discussions that commenced during the event allowed for greater interaction between Department of Health staff and the District's stakeholders. The meeting ended with several participants inquiring about the possibility of continuing these types of discussions in the near future, and making open dialogue a part of the continued priority setting process. By and large, the meeting can be considered to have been a success for all stakeholders and Department of Health staff alike.

[7] For the selection of recommendations, attendees were provided with five cards labeled 1 through 5 and a set of pre-printed labels of 20 possible priority recommendations. These labels included all of the priorities chosen as a result of the 2005 needs assessment as well as 11 additional choices that were developed based on information gathered in this year's assessment. Attendees were also free to write in their own selections.

Table 16

D.C. Maternal and Child Health Community Forum

Stakeholder Recommendations
(Recommendations receiving ten or more points.)

	Ranking					
Priority	#1=10	#2=8	#3=6	#4=4	#5=2	**Total Points**
Reduce unintended pregnancies/teen births	3	4	3	1	7	98
Decrease infant mortality	5	2	1	3	2	88
Increase knowledge of available services	2	2	3	5	1	76
Improve special health care needs diagnosis in schools	3	3	3	0	2	76
Improve access to medical services	1	2	6	1	2	70
Enhance nutrition/physical activity	3	1	0	5	4	66
Increase recreational programs for youth	1	4	2	2	0	62
Increase access to medical homes for CSHCN	2	4	1	1	0	62
Increase access to prenatal care	2	1	2	4	3	62
Increase home visiting programs	4	1	0	0	0	48
Increase availability of licensed child care	2	1	0	1	6	44
Decrease low-birth-weight births	0	3	3	0	0	42
Improve/increase health insurance coverage	0	2	2	2	2	40
Decrease violence	2	1	1	0	3	40
Improve/increase mentoring programs	0	1	3	2	2	38
Improve oral health	1	2	0	2	0	34
Improve/increase sex education	0	1	1	4	1	32
Increase access to mental health services	1	2	1	0	0	32
Increase collaboration/coordination among agencies	1	1	0	2	2	30
Reduce sexually transmitted diseases	0	1	2	2	0	28
Decrease preterm births	0	1	2	1	1	26
Increase transition services for CSHCN	2	0	0	0	0	20
Increase programs to improve parenting skills	1	0	0	0	0	10
Improve and expand early intervention services	1	0	0	0	0	10
Increase pediatric palliative care services	1	0	0	0	0	10

8. Conclusion.

The goal of this needs assessment was to present data that can be used by the D.C. Department of Health and the greater District community to implement Title V programming in the most efficient manner possible. To do so, both quantitative and qualitative data were collected to determine the most pressing needs for various target populations.

Quantitative research, base mainly upon indicators collected by the Centers for Disease Control and the D.C. Department of Health suggest that areas of MCH concern in the District include: preterm births and the students consuming the recommended amount of fruits and vegetables (2007 as compared to 1999), which have both deteriorated over time. In addition to problems that have worsened, there were several indicators showing that certain conditions in the District were worse than they were nation, these include: use of early prenatal care, student perceptions of school safety, child victimization, reported gonorrhea and chlamydia, and CSHCN families reporting that youth receive the necessary services to adequately transition to adulthood.

The indicators that were of the greatest concern were those that 1) have worsened over time and 2) were worse in the District, as of the most recent measurement, than they were in the nation as a whole. These indicators include: infant mortality, obesity among students, students involved in a physical fight over the past year, students reporting that they have ever had asthma, and CSHCN families reporting that they do not have engage in coordinated, ongoing comprehensive care in a medical home. Many of the areas of need uncovered in the quantitative analysis of MCH indicators in the Washington, D.C. were also noted in the focus groups and key informant interviews.

Perhaps the greatest benefit of the focus groups was that, in addition to addressing general needs, participants discussed the effectiveness of particular programs that focus upon MCH in the District. In terms of what is working best for pregnant women, mothers and infants, the most popular responses by far were the WIC program and prenatal care and obstetrics/gynecology services in D.C. For children and adolescents, the most frequently mentioned programs were Covenant House, the Boys and Girls Club, the Arc of D.C. and the Children's National Medical Center. The latter was also the most popular with regard to CSHCN.

As for what was considered to be not working well, the TANF program was very unpopular when discussing services for pregnant women, mothers and infants. When the topic turned to children and adolescents, while no particular program was mentioned multiple times, the lack of recreational activities and the perceived lack of parenting skills among young parents were frequently noted. For CSHCN, IEPs as administered by the D.C. public school system were commonly stated to be inadequate, and respondents complained that children's special needs were too often misdiagnosed or mistreated.

With respect to what is working well in the District, the findings from the key informant interviews largely echoed those of the focus groups. However, interviewees also raised additional concerns that were not as explicitly addressed in the focus group. For example, while multiple key informants joined focus-group participants in citing prenatal care as an area that is going well in the District, several of the interviewees also pointed to this area as one of the biggest challenges — a result that, on both accounts, is consistent with the quantitative data, which show increasing use of early prenatal care in the District over time, but at levels that consistently lag the nation as a whole. To increase the effectiveness of Title V programs and general MCH in Washington D.C., interviewees most often suggested restructuring the D.C. Department of Health

to eliminate ineffective processes and bureaucracy, involving the community and encouraging dialogue, and only funding quality programs.

The D.C. Maternal and Child Health Community Forum provided the opportunity for members of the community and professionals involved in maternal and child health services to become aware of the results of the Title V needs assessment process, and make informed recommendations to the Department of Health regarding what they felt should be the top priorities over the next five years in the District of Columbia. The top five priorities identified at the forum were to reduce unintended pregnancies/teen births, decrease infant mortality, increase knowledge of available services, improve the efficiency of special health care needs diagnosis in schools, and improve access to medical services.

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Appendix A: Supplemental Focus Group Information.

A.1. Participating Organizations for Title V Focus Groups.

The following organizations/groups assisted in the development of the focus groups that were held from November 2009 through January 2010:

- Advocates for Justice and Education.
- Catholic Charities, James Cardinal Hickey Center.
- Children's National Medical Center.
- Columbia Heights/Shaw Family Support Collaborative.
- Concerned Parents of Petworth (CPOP).
- Edgewood/Brookland Family Support Collaborative.
- Georgia Avenue/Rock Creek East Family Support Collaborative.
- Healthy Babies Project, Inc.
- Health Services for Children with Special Needs, Inc. (HSCSN).
- Lutheran Social Services of the National Capital Area.
- Mary's Center for Maternal and Child Care, Inc.

Representatives from the following organizations/groups participated in the expert focus group:

- D.C. Department of Health, Community Health Administration.
- D.C. Hunger Solutions.
- D.C. Pediatric Palliative Care Collaboration.
- D.C. Public Schools, Early Stages Program.
- D.C. Rehabilitation Services Administration, Disability Determination Division (DDD).
- Children with Special Health Care Needs (CSHCN) Advisory Board.
- Family Voices of D.C.
- Georgetown University, Department of Pediatrics.
- HSC Pediatric Center.
- Metropolitan Area Communication Service (MACS).
- Male Caregivers Advocacy Support Group.
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

Thank you to everyone who helped organize and/or participated in the 2010 Title V focus groups. Your help is greatly appreciated.

A.2. Focus Group Questions.

District of Columbia

Department of Health, Community Health Administration

2010 Title V Needs Assessment

FOCUS GROUPS

Questions:

1. In your opinion, what are the best services in D.C. for each of the following groups? These can be services you have heard about, services provided in your line of work, or services that you or your family have used personally.

    1. Pregnant women, mothers and infants?
    2. Children and adolescents (or teens)?
    3. Children with special health care needs and their families?

2. For the three groups we discussed — pregnant women, mothers and infants; children and teens; and special-needs children and their families — what isn't working? What are the barriers to care these folks face?

    1. Pregnant women, mothers and infants?
    2. Children and adolescents (or teens)?
    3. Children with special health care needs and their families?

3. Of those who you said are not receiving adequate care or services, what do you believe should be done in D.C. to help them?

    1. Pregnant women, mothers and infants?
    2. Children and adolescents (or teens)?
    3. Children with special health care needs and their families?

4. Do children and families in your neighborhood or community have adequate insurance to pay for the services they need?

5. What other problems/concerns are facing children and families in your neighborhood or community?

6. Are there other serious issues in your neighborhood or community (such as domestic violence, sex education, asthma, oral health, lead poisoning, etc.)?

7. Have there been any recent changes among children and families in your community? Please state the changes. These changes can be positive or negative.

8. Where do mothers, infants, children and adolescents in your community go to receive services or help that they need? Do they encounter any obstacles?

9. Is there anything else about your community that you have not mentioned yet that you feel is important?

Thank you!

A.3. Other Focus Group Responses (Mentioned in One Group Each).

A.3.1. Best Services/Initiatives.

Pregnant Women, Mothers and Infants (Ages Birth to 3):

- D.C. Children and Youth Investment Trust.
- Bilingual services at Mary's Center for Maternal and Child Care.
- Even Start program at Mary's Center for Maternal and Child Care.
- Supplies for infants from Family Place and the Northwest Clinic.
- D.C. Cribs program.
- Mammograms and cancer screening.
- Programs for smoking cessation.
- Pregnancy Crisis Center on Capitol Hill.
- United Planning Organization (UPO).
- Teen Alliance for Prepared Parenting program at Washington Hospital.

Children and Adolescents (Ages 4 to 24):

- Young Adults Internship program.
- D.C. Children and Youth Investment Trust.
- Americorps.
- Foster care programs.
- Health insurance coverage, both public and private.
- Programs for homeless children.
- Job training programs for teens.
- Young Lives program.
- Best Friends Foundation.
- Community Connections.
- Young Men's Christian Association.
- My Mother's House.
- Immunization campaigns.
- Mobile health units (vans).
- Upper Cardoza.
- Bread for the City.

Children with Special Health Care Needs (CSHCN) and Their Families:

- Transplant services.
- Hospital for Sick Children.
- Kennedy Institute.
- Arts and Drama Center.

- St. Colletta.
- Kids Enjoy Exercise Now (KEEN) program.
- The School for Arts in Learning (SAIL).
- Life for Skills program.
- 24-Hour health centers.
- Some special education programs in public schools.
- Some specialized schools.
- Managed health care plans.
- Advocates for Justice and Education (AJE).
- Parent Magazine.

A.3.2. Services that are Not Working Well.

Pregnant Women, Mothers and Infants (Ages Birth to 3):
- N/A.

Children and Adolescents (Ages 4 to 24):
- No outreach programs.
- Lack of job training.
- Lack of nutritional programs.

Children with Special Health Care Needs (CSHCN) and Their Families:
- Tendency to over-medicate.
- Few physicians accepting CSHCN, especially those with Medicaid.

For All Groups:
- Certain hospitals turn away the uninsured.
- High health insurance premiums.
- Poor health outcomes.
- High turnover at the D.C. Department of Health.
- Court system is separating families.
- Families are forced to go to clinics in their neighborhoods, which are overcrowded and often don't provide the care they need.

A.3.3. What Should be Done to Help?

Pregnant Women, Mothers and Infants (Ages Birth to 3):
- More programs overall.
- TANF needs to be restructured.
- Education regarding available services.
- Parents need to be heard.
- Parents need to be active in schools.

Children and Adolescents (Ages 4 to 24):

- Need a social worker assigned to a child.
- Sex education and family planning for teens (encourage them to not have a second baby).
- WIC and food stamps should cover more nutritious and hot foods.
- Need positive role models.

Children with Special Health Care Needs (CSHCN) and Their Families:

- Should receive equal treatment in hospitals.
- Need positive role models.
- Need more Medicaid accepting physicians for CSHCN.
- Mental health services for CSHCN.
- Home health care.
- Advertising about services and media campaigns to decrease stigma regarding disabilities.
- Affordable child care for CSHCN.

Men:

- Job-training and workforce development for fathers.
- Need to change male attitudes about having children — often considered a rite of passage/manhood.

For All Groups:

- Co-location of services.
- Better geographic distribution of services.

A.3.4. Insurance Coverage.

- Coverage for palliative care.
- Especially difficult to get coverage for dental care and specialty care for CSHCN.
- Medicaid model encourages over-medication.
- Public insurance specifically for CSHCN should be offered.

A.3.5. Other Problems, Concerns and Serious Issues Facing Communities.

- HIV/AIDS.
- Lack of respect for one another.
- Lack of mental health and substance-abuse services.
- Poverty.
- STDs/STIs among formerly incarcerated.
- Hunger — school breakfast programs have been cut.
- Difficulty accessing grocery stores ("food deserts").
- Lack of preventive services.
- Teenagers fighting their parents (physically).
- Difficulty accessing oral health care.

- Rape.
- Stereotyping and discrimination.
- Untreated mental health issues.
- Opportunities for improvement in care coordination.
- Lack of hospice and end-of-life care, especially for CSHCN.
- Reimbursement issues for services for CSHCN.
- Stigma.
- Early intervention services are lacking.
- Child abuse/neglect tracking system is weak.
- Few obesity treatment clinics and primary care doctors can't effectively diagnose.

A.3.6. Recent Changes.

- Prostitution an increasing issue.
- Kids are exposed to negative behaviors.
- WIC program is improving — providing more diverse and nutritious foods.
- Fathers are becoming more involved — more male caregivers.
- Increased presence of gangs.
- Cases of sudden infant death syndrome (SIDS) are increasing.
- Kids are destroying public property.
- Some kids are giving back to the community.
- Pollution.
- Media campaigns make STDs seem less serious than they are.

A.3.7. Where Do Families Go to Receive Services?

- D.C. General.
- Greater Southeast Hospital.
- Georgetown University Hospital.
- George Washington Hospital.
- Food donation centers (lunch trucks come into neighborhoods in Ward 8).
- Washington Hospital.
- 2100 Martin Luther King, Jr. Avenue clinic.
- 645 H Street public assistance center.
- D.C. Department of Social Services.
- D.C. Department of Health.
- Early childhood mental health assessment centers.

A.3.8. Other Topics of Concern.

- Stigma regarding diseases and disabilities.
- People can't access emergency services because residents go to the emergency rooms for routine care.
- People abusing the system and ruining it for others.
- Ineffective ex-offender programs.
- Section 8 process and difficulty filing paperwork.
- Distrust in the police.
- Bad credit scores.
- Cultural sensitivity.
- Literacy.
- Waiting lists for subsidized child care.
- Unregulated residential buildings.
- Few job training programs.
- Lack of faith and trust in the government.
- TANF program needs restructuring.
- Surprise drug testing for school staff and bus drivers.
- Social workers and outreach workers need to come into the community.
- Lack of positive role models for kids.
- Need culturally sensitive programs that acknowledge literacy levels.
- Public agencies' commitments to follow-up on assessments (want to see results from all these focus groups and interviews that are conducted).
- Transparency in public agencies.
- Electronic patient records needed throughout D.C.
- Lack of public data about D.C. children and families.

Appendix B: Supplemental Key Informant Interview Information.

B.1. Participating Organizations for Key Informant Interviews.

Individuals from the following organizations participated in key informant interviews for the 2010 Title V needs assessment:

1. Advocates for Justice and Education.
2. Assembly of Petworth.
3. Children's National Medical Center (CNMC).
4. D.C. Primary Care Association.
5. Edgewood/Brookland Family Support Collaborative.
6. Epilepsy Foundation.
7. Healthy Babies Project.
8. Howard University.
9. March of Dimes.
10. Mary's Center for Maternal & Child Care.
11. National Alliance to Advance Adolescent Health.

B.2. Questions.

Key informant interview questions, October and November 2009.

1. What are the top three services/initiatives that are working well in the District for pregnant women? Mothers? Infants? Children? Children with special health care needs and their families? Adolescents? (Indicate whether each activity is direct, enabling population-based or infrastructure.)

2. What are the top three services/initiatives that are not working well in the District for pregnant women? Mothers? Infants? Children? Children with special health care needs and their families? Adolescents? (Indicate whether each activity is direct, enabling population-based or infrastructure.)

3. What are some things that can be done to address these gaps or unmet needs for pregnant women? Mothers? Infants? Children? Children with special health care needs and their families? Adolescents? (Please suggest a minimum of two examples for each population.)

4. In your opinion, what are the three biggest challenges facing pregnant women in the District of Columbia? Mothers? Infants? Children? Children with special health care needs and their families? Adolescents?

5. Are there any other unmet needs (such as domestic violence, sex education, asthma, oral health, lead poisoning) that you can think of that have not yet been mentioned?

6. Please provide some examples of outcome indicators used by your program/agency to measure program performance to meet the needs of pregnant women. Mothers? Infants? Children? Children with special health care needs and their families? Adolescents?

7. In general, how well do the various agencies and organizations collaborate in the District to serve the needs of the MCH population? What suggestions do you have to make collaborations stronger?

8. Can you name any areas where collaborations/partnerships don't exist or are weak?

B.2.1. Additional Questions Specifically for Children with Special Health Care Needs.

9. Do you believe families of children with special needs partner in decision-making at all levels for their children, and are satisfied with the services in DC? What recommendations do you have for improvement?

10. To what degree do CSHCN families and caregivers receive coordinated, ongoing, comprehensive care within a medical home? Recommendations for improvement? Suggestions to solicit client complaints/feedback?

11. Do you think CSHCN families have adequate insurance to pay for the services they need?

12. To what degree do you feel that CSHCN are screened early and continuously for special health care needs?

13. Do you feel that CSHCN services are coordinated so that families can easily use them?

14. Do you feel that youth with special needs have received the services necessary to make appropriate transitions to adult health care, work and independence? Recommendations for improvement?

B.3. Other (One Mention Each) Key Informant Interview Responses

B.3.1. Services/Initiatives that Are Working Well.

Pregnant Women:

- Neonatal intensive care units or NICUs (education and support they provide for families).
- Referrals for other services.
- Mary's Center lead program.
- Maternal and Child Health Bureau at the D.C. Department of Health (advocacy, planning and service coordination).
- I Am a D.C. Healthy Mom Consortium.
- Healthy Start.
- Healthy Babies Project.
- Momma and Baby Bus.
- D.C. Medicaid Program.
- D.C. Program for Life.
- Provident Hospital Center for Life.

- Unity Health Care.
- Case management services.

Mothers:

- Day care vouchers.
- Links to employment.
- Mobile vans.
- NICUs (education and support they provide for families).
- Referrals for other services.
- Counseling (victims of domestic violence).
- Safe Cribs program.
- TANF.
- Food Stamps.
- I Am a D.C. Healthy Mom Consortium.
- D.C. Developing Families Center.
- Momma and Baby Bus.
- D.C. Medicaid Program.
- HSC Pediatric Center.

Infants:

- Mobile vans.
- Referrals for other services.
- Agency collaboration.
- Project Rose.
- Car seat campaign.
- Case management services for families with infants.
- Healthy Start.
- Infant mortality (overall decrease).
- Ages and Stages screening program.
- Early Head Start.

Children:

- Family Voices of D.C.
- Mobile vans.
- Referrals for other services.
- Safety in schools.
- Private day care.
- Other schools options (charter, magnet and private).
- Developmental testing.

- Children's Hospital.
- Mary's Center lead program.
- Tuberculosis screening programs.
- Hospital for Sick Children.
- Child-care centers.
- Recreational activities/programs.

CSHCN:

- HSC Pediatric Center.
- Advocates for Justice and Education.
- Special-needs schools.
- D.C. Gaps program.
- Dedicated Service Coordination grant.
- SCHIP insurance program.
- D.C. Alliance.
- Organizational partnering.
- Hospital for Sick Children.
- Referrals for specialty care.

Adolescents:

- Mobile vans.
- Sex education programs.
- Advocacy (through Advocates for Justice and Education and others).
- HIV/AIDS testing.
- Tutoring/mentoring programs.
- Work eradicating gang violence.
- Adolescent pregnancy programs.
- Volunteer Income Tax Assistance grants.
- Primary care for adolescents (readily available, but not always accessed).

B.3.2. Services/Initiatives that are Not Working Well.

Pregnant women:

- Child care in school (lack of).
- School-based health centers.
- Emergency hotline (311).
- Oral health care.
- WIC program for immigrant populations.
- Lack of a coordinated effort (fragmented services).

- STD/STI reduction efforts.
- Early care education.
- Incidence of domestic violence.

Mothers:

- Incidence of domestic violence.
- Housing (cost and accessibility).
- Shelters (often have to turn people away).
- D.C. Department of Health.
- Lack of a coordinated effort (fragmented services).
- Sex education programs.
- Eligibility requirements for subsidized child care and other services (reduces the incentive to work).
- D.C. public schools (quality of education and unsafe environments).
- Emergency hotline (311).
- STD/STI reduction efforts.
- Lack of follow-up for new mothers.
- Oral health care (quality and accessibility).
- D.C. Healthy Moms for immigrant populations.
- Lack of culturally appropriate public information for mothers.
- Safe Cribs program for immigrant populations.
- Child care in schools.
- School-based health centers.

Infants:

- Lack of substance abuse and mental-health services for parents.
- Unsafe sleep practices/misperceptions regarding "crib death."
- Homelessness of families.
- Competition for funding affecting the quality of services for infants.
- Lack of a coordinated effort (fragmented services).
- Affordable, quality child care.

Children:

- Child Protective Services (lack of follow-up on reported cases).
- Reimbursement issues impacting service providers and their willingness to offer services.
- Budget cuts resulting in cuts to mental-health services in schools.
- Quality of medical care for Medicaid clients.
- Waiting lists for medical appointments.
- Lack of after-school programs.

- Lack of culturally sensitive information for immigrant children (teaching them how to assimilate).
- Exposure to violence.
- Lack of positive role models.
- Constant fear and stress.
- Unsafe living conditions.
- Absence of fathers.
- Lack of investment by the city in neighborhoods.
- Peer navigators for peer support programming aren't adequately trained, and therefore aren't always helpful.

CSHCN:

- Transportation.
- Affordable, quality child care for CSHCN.
- Lack of trained nurses in school for children with asthma.
- Lack of nurses in schools in general.
- School-based health care.
- Lack of parent-support groups.
- HIV/STD reduction efforts.
- Lack of follow-up from services.
- Early intervention services are weak.
- Lack of a push for funding from leadership for CSHCN.
- Lack of information about available services.
- Education for parents about how to prevent birth defects in future children.
- Lack of birth defect surveillance system in D.C.
- Lack of specialized child care in D.C. for CSHCN.
- Few medical homes.
- Reimbursement issues impacting service providers and their willingness to offer services.
- Difficulty obtaining adequate health insurance for CSHCN, including prescription coverage.
- Quality of care for Medicaid insured.
- Waiting lists for services.
- Transition services (lack of and quality of existing services).

Adolescents:

- Lack of holistic health care (confronting physical, mental and reproductive health issues).
- Accessing annual well visits/preventive care.
- Lack of mental-health services and counseling.

- Weak outreach services.
- Lack of behavioral health counseling.
- Lack of family planning programs.
- After school programs (availability of and information about existing programs).
- Dropping out of school.
- Teen pregnancy.
- Lack of mentoring programs.
- Violence (gang-related and domestic).

B.3.3. Biggest Challenges.

Pregnant women and mothers:

- Lack of affordable housing.
- Lack of free, quality job training.
- Apprenticeship programs.
- Lack of follow-up, maintaining in care.
- Needs of other children create challenges for accessing care.
- Poverty.
- Stress.
- Depression.

Infants:

- Affordable, quality infant care.
- Poverty.
- Mental health and substance-abuse issues among parents.
- Unsafe environments.

Children:

- Poor role models.
- Violence in neighborhoods.
- Unsafe environments.

CSHCN:

- CSHCN aren't actively engaged in their own care.
- Referrals for other services.
- Medicaid reimbursement issues.
- Educating parents about issues concerning CSHCN and how to care for their own children.
- Transition planning services.
- Stigma regarding special health care needs and myths regarding treatment.
- Enabling services such as transportation.

Adolescents:

- After school programming.
- D.C. public schools (quality of education).
- Not encouraged to succeed in school or go to college.
- Unsafe environments.
- Poverty.

Overall challenges:

- Lack of leadership at the D.C. Department of Health.
- Role of bureaucracy in the funding process.
- Funding being used to fund salaries rather than create programs.
- High rate of turnover in public agencies.
- Unintended pregnancy.
- Domestic violence.
- Lack of training.
- D.C. public schools.
- Childhood obesity and lack of nutritional counseling.

B.3.4. Other Unmet Needs.

- Prevention and early intervention efforts.
- Teen pregnancy/unintended pregnancy.
- Lack of cultural/socio-economic sensitivity among MCH professionals (patients not being treated well because of cultural differences or economic status).
- Misperceptions and stigma.
- Geographic distribution of MCH services.
- Poverty.
- D.C. public schools (quality of education and unsafe environments).
- Lack of affordable housing.
- Education for parents of CSHCN so they can understand their child's condition and treatment.
- Childhood obesity.
- Diabetes.

B.3.5. Recommendations for Improvement.

- Apprenticeship/vocational programs in schools (teaching students a trade)
- Electronic medical records.
- Investment by the city in neighborhoods and MCH services.
- Peer counseling.

- Setting goals, strategies and clear priorities.
- Grant funding needs to be better managed (accountability for subcontractors).
- Restructure reimbursement/payment processes.
- Public/private partnerships (collaboration with community organizations who actually understand and can effectively access the populations in need).
- More funding for violence-reduction efforts and shelters for victims.
- Prioritize safety in the communities.
- Peer navigators for mothers.
- Improved oral health care.
- Restructure eligibility requirements for services.
- Reform of the health care system.
- 24-hour infant care centers.
- Focus on geographic distribution of health care centers.
- Make sexual health part of on-going care for adolescents.

B.3.6. Outcome Indicators.

- Responses to training.
- Identifying best practices, other state approaches.
- Feedback at forums (discussion among clients).
- Returns on investment.

Appendix C: Supplemental Maternal and Child Health Community Forum Information.

C.1. Participating Organizations for the Maternal and Child Health Community Forum.

Individuals from the following organizations, as well as members of the community, participated in the 2010 Maternal and Child Health Community Forum:

1. Arthritis Foundation
2. Assembly of Petworth
3. B.E.A.T. for Health (Building Educational Alternatives Together for Health)
4. Bread for the World
5. Carson Company, LLC
6. Center for Child Protection & Family Support
7. Children's National Medical Center
8. D.C. Appleseed Center
9. D.C. Birthing Project
10. D.C. Campaign to Prevent Teen Pregnancy
11. D.C. Department of Health, Community
12. D.C. Department of Mental Health
13. D.C. Department on Disability Services
14. D.C. Healthy Start
15. D.C. Hunger Solutions
16. D.C. Pediatric Palliative Care Collaboration
17. D.C. Public Schools, Office of Youth Engagement
18. D.C. WIC Program
19. Developing Families Center
20. Eagle Academy Public Charter School (PCS)
21. Empower D.C., Child Care for All Campaign
22. Family Voices of D.C.
23. GTU-NIH-D.C. Initiative
24. Hatcher-Dubois-Odrick Group, LLC
25. Health Administration
26. Health Services for Children with Special Needs, Inc.
27. Howard University Hospital (HUH) Cares Program
28. InterGroup Services, Inc.
29. Lupus Foundation of America
30. M.O.M.I.E.'s TLC (Mentors of Minorities in Education's Total Learning Cis-Tem)
31. Mary's Center for Maternal and Child Care, Inc.
32. National Alliance to Advance Adolescent Health
33. Peaceoholics, Inc.
34. Pediatric AIDS/HIV Care, Inc.
35. Planned Parenthood of Metropolitan Washington

36. Providence Hospital
37. Quality Trust for Individuals with Disabilities
38. RAND Corporation
39. Reading is Fundamental (RIF)
40. Restoration Ministries
41. Southeastern University, Center for Allied Health Education
42. The Arc of the District of Columbia, Inc.
43. The D.C. Children's Advocacy Center
44. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau
45. University of Maryland, School of Public Health

Appendix D: Statistical Supplement.

C.1. Methodology.

The Centers for Disease Control and Prevention (CDC) are the original source for all the material that follows in this appendix. The CDC reports the weighted percentages and the related 95-percent confidence interval. In order to compare two of these percentages (without having access to the CDC's weights) we use the formula (based on the central limit theorem) for calculating confidence intervals from proportions to estimate N.

Y : upper boundary of the 95 - percent confidence interval reported by CDC.

$\hat{p}$: percentage reported by CDC.

$$Y_i = \hat{p}_i + 1.96\sqrt{\frac{\hat{p}_i\,(1-\hat{p}_i)}{N_i}} \quad \ldots \quad N_i = \frac{1.96^2 * \hat{p}_i\,(1-\hat{p}_i)}{(Y_i - \hat{p}_i)^2}$$

We then use the aforementioned percentage to calculate the N for each cell.

$$A_1 = \hat{p}_1 * N_1 \qquad A_2 = \hat{p}_2 * N_2$$
$$B_1 = (1-\hat{p}_1) * N_1 \qquad B_2 = (1-\hat{p}_2) * N_2$$

Using the cell counts, we are able to calculate odds ratios and the standard error of the natural logarithm of the odds ratios.

$$OR = \frac{A_1 * B_2}{B_1 * A_2}$$

$$S.E._{\ln(OR)} = \sqrt{\frac{1}{A_1} + \frac{1}{B_1} + \frac{1}{A_2} + \frac{1}{B_2}}$$

We use the standard errors to construct 95-, 99-, and 99.9-percent confidence intervals for the natural logarithm of each odds ratio; the exponents of which are the respective confidence intervals for the untransformed odds ratios. The results are presented in the tables that follow. (Alternatively, the same initial process could have been used to generate N_1 and N_2 for the two-sample difference of proportions test, which yields the exact same results with respect to statistical significance.)

C.2. Results.

Table 17

Odds Ratios of Washington, D.C. to Nearby Jurisdictions

		Prince George's *OR (95%-CI)*	Alexandria *OR (95%-CI)*	Arlington *OR (95%-CI)*	Fairfax *OR (95%-CI)*
Washington, D.C., 2007†	**Fig. 13**	0.91 (0.67-1.23)	1.31 (0.67-2.55)	**1.68 (1.04-2.74)***	1.38 (0.73-2.61)
	Fig. 15	**1.68 (1.06-2.68)***	1.07 (0.58-1.96)	0.62 (0.29-1.31)	**0.47 (0.24-0.93)***
	Fig. 16	**1.89 (1.29-2.76)****	0.65 (0.41-1.05)	**0.59 (0.38-0.92)***	0.95 (0.55-1.62)
	Fig. 19	1.22 (0.89-1.69)	1.79 (0.89-3.60)	1.41 (0.74-2.68)	1.97 (0.98-3.96)
	Fig. 21	1.19 (0.85-1.65)	1.14 (0.55-2.38)	0.97 (0.57-1.66)	1.11 (0.62-2.00)
	Fig. 23	0.67 (0.40-1.13)	1.97 (0.80-4.90)	1.55 (0.67-3.57)	0.74 (0.27-2.05)
	Fig. 24	1.32 (0.78-2.25)	0.91 (0.46-1.81)	**6.07 (2.23-16.48)*****	**3.64 (1.15-11.51)***
	Fig. 25	1.36 (0.97-1.89)	0.91 (0.51-1.64)	1.25 (0.74-2.11)	0.63 (0.33-1.20)
	Fig. 26	**1.35 (1.04-1.74)***	0.96 (0.57-1.64)	**0.53 (0.35-0.79)****	**0.46 (0.28-0.73)****
	Fig. 28	1.24 (0.98-1.58)	1.03 (0.68-1.57)	0.81 (0.57-1.14)	1.27 (0.85-1.89)
	Fig. 29	0.76 (0.57-1.02)	**3.52 (1.44-8.63)****	— —	— —
	Fig. 30	0.87 (0.70-1.08)	1.19 (0.77-1.85)	**1.81 (1.25-2.63)****	1.35 (0.89-2.04)
	Fig. 31	**0.59 (0.40-0.87)****	0.56 (0.29-1.09)	0.74 (0.40-1.34)	1.52 (0.69-3.31)

†The odds ratio is the comparison of the odds of a resident of the District giving a particular response to the odds of residents from the jurisdiction at the top of a given column. Numbers greater than one mean the odds of District residents are higher than those of the respective jurisdiction; odds less than one mean that District residents have lower odds; and an odds ratio of one means that District residents have odds equal to those of residents from the relevant jurisdiction. Only odds ratios in bold can be statistically distinguished from equal odds at, at least, the 95-percent confidence level.

* denotes p≤.05; ** denotes p≤.01; *** denotes p≤.001.

Figure Title and Location

Figure 13: Health Status “Fair” or “Poor” (p. 14)
Figure 15: Heavy Drinkers (p. 15)
Figure 16: Binge Drinkers (p. 16)
Figure 19: Adults Who Are Currently Smokers (p. 17)
Figure 21: Adults Who Have Been Told They Currently Have Asthma (p. 17)
Figure 23: Adults Who Have Ever Been Told They Have Angina or Coronary Heart Disease (p. 18)
Figure 24: Adults Who Have Ever Been Told They Had a Heart Attack (p. 18)
Figure 25: Adults Who Have Had Their Blood Cholesterol Checked Within the Last Five Years (p. 19)
Figure 26: Adults Who Participated in Any Physical Activity in Past Month (p. 19)
Figure 28: Adults Who Consume Fruits and Vegetables Five of More Times Per Day (p. 20)
Figure 29: Adults Who Have Ever Been Told by a Doctor They Have Diabetes (p. 20)
Figure 30: Adults Who Have Ever Been Told They Have High Blood Pressure (p. 20)
Figure 31: No Health Insurance Reported (p. 21)

Table 18

Odds Ratios of Washington, D.C., Longitudinal and Compared to Prince George's County

		2002 *OR (95% CI)*	2003 *OR (95% CI)*	2004 *OR (95% CI)*	2005 *OR (95% CI)*	2006 *OR (95% CI)*	2007 *OR (95% CI)*	2008 *OR (95% CI)*	2008 v. 2002[c] *OR (95% CI)*
Fig 14	Prior Year[a]:	— —	1.15 (0.90-1.47)	0.87 (0.69-1.09)	1.16 (0.95-1.41)	1.05 (0.87-1.26)	1.01 (0.84-1.21)	1.06 (0.89-1.27)	**1.29 (1.03-1.62)***
	Prince George's[b]:	1.04 (0.70-1.56)	1.19 (0.76-1.88)	0.99 (0.67-1.47)	1.32 (0.98-1.77)	1.00 (0.71-1.41)	0.91 (0.67-1.23)	1.22 (0.86-1.73)	— —
Fig 17	Prior Year[a]:	— —	1.05 (0.77-1.42)	0.98 (0.72-1.34)	**0.73 (0.55-0.97)***	1.02 (0.78-1.34)	1.02 (0.78-1.33)	1.25 (0.95-1.63)	0.97 (0.73-1.29)
	Prince George's[b]:	1.03 (0.78-1.36)	**1.77 (1.02-3.06)***	1.94 (0.97-3.90)	**2.04 (1.16-3.58)***	**2.97 (1.54-5.70)****	**1.68 (1.06-2.68)***	1.60 (0.80-3.21)	— —
Fig 18[c]	Prior Year[a]:	— —	— —	— —	— —	— —	1.09 (0.92-1.29)	1.09 (0.91-1.31)	[c]1.18 (0.99-1.42)
	Prince George's[b]:	— —	— —	— —	— —	**2.27 (1.47-3.49)*****	**1.89 (1.29-2.76)****	**1.98 (1.34-2.92)*****	— —
Fig 20	Prior Year[a]:	— —	1.09 (0.89-1.34)	0.94 (0.78-1.13)	0.94 (0.80-1.10)	0.87 (0.74-1.02)	0.96 (0.81-1.14)	0.94 (0.79-1.13)	**0.75 (0.62-0.92)****
	Prince George's[b]:	1.44 (0.97-2.12)	**1.56 (1.09-2.21)***	1.20 (0.86-1.66)	1.12 (0.87-1.44)	1.02 (0.76-1.38)	1.22 (0.89-1.69)	**1.45 (1.08-1.93)***	— —
Fig 22	Prior Year[a]:	— —	0.84 (0.63-1.12)	1.19 (0.92-1.53)	1.00 (0.79-1.26)	1.11 (0.89-1.38)	0.91 (0.74-1.11)	1.14 (0.91-1.42)	1.14 (0.87-1.50)
	Prince George's[b]:	1.13 (0.68-1.89)	1.12 (0.67-1.89)	1.47 (0.93-2.31)	1.07 (0.76-1.50)	0.98 (0.70-1.37)	1.19 (0.85-1.65)	1.20 (0.84-1.72)	— —
	Baltimore City	0.88 (0.53-1.47)	1.09 (0.64-1.85)	0.98 (0.61-1.58)	0.74 (0.52-1.06)	1.08 (0.75-1.54)	0.82 (0.59-1.15)	1.16 (0.82-1.64)	— —
Fig 27	Prior Year[a]:	— —	0.92 (0.75-1.12)	1.01 (0.84-1.21)	0.99 (0.85-1.15)	1.03 (0.89-1.19)	1.04 (0.90-1.20)	1.02 (0.88-1.19)	1.00 (0.84-1.20)
	Prince George's[b]:	1.14 (0.82-1.59)	1.20 (0.87-1.64)	0.99 (0.74-1.33)	1.24 (1.00-1.54)	1.09 (0.84-1.42)	**1.35 (1.04-1.74)***	1.19 (0.94-1.50)	— —
Fig 32	Prior Year[a]:	— —	1.15 (0.83-1.59)	1.10 (0.83-1.45)	0.90 (0.70-1.16)	0.88 (0.68-1.14)	1.00 (0.79-1.27)	1.10 (0.84-1.44)	1.10 (0.80-1.51)
	Prince George's[b]:	**1.61 (1.01-2.56)***	**1.63 (1.01-2.16)***	0.97 (0.61-1.55)	**1.54 (1.10-2.16)***	**1.53 (1.03-2.26)***	**1.70 (1.15-2.50)****	**2.16 (1.50-3.11)*****	— —

* denotes p≤.05; ** denotes p≤.01; *** denotes p≤.001.

[a] The odds ratio presented is the comparison of the percentage in a given year (e.g., 2003) to that of the percentage in the previous year (e.g., 2002).
[b] The odds ratio presented is the comparison of percentage of residents from Washington, D.C. to those of residents of Prince George's County in a given year.
[c] The odds ratio presented is the comparison of the percentage in 2008 to the percentage in 2002 (or, in the case of figure 18, 2006).

Figure Title and Location
Figure 14: Health Status "Fair" or "Poor," 2002 to 2008, D.C. versus Prince George's County, Md. (p. 15)
Figure 17: Heavy Drinkers, 2002 to 2008, D.C. versus Prince George's County, Md. (p. 16)
Figure 18: Binge Drinkers, 2002 to 2008, D.C. versus Prince George's County, Md. (p. 16)
Figure 20: Adults Who Are Currently Smokers, 2002 to 2008, D.C. versus Prince George's County, Md. (p. 17)
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Figure 27: Adults Who Participated in Any Physical Activity in Past Month, 2002 to 2008, D.C. versus Prince George's County, Md. (p. 19)
Figure 32: Health Care Coverage, 2002 to 2008, D.C. versus Prince George's County, Md. (p. 21)

Table 19

Odds Ratios of Washington, D.C., Longitudinal and Compared to the United States

		1997 *OR (95% CI)*	1999 *OR (95% CI)*	2003 *OR (95% CI)*	2005 *OR (95% CI)*	2007 *OR (95% CI)*	2007 v. 1997[c] *OR (95% CI)*
Fig 52	D.C. Prior[a]:	— —	— —	— —	— —	**1.40 (1.12-1.70)****	— —
	U.S.[b]:	— —	— —	1.12 (0.90-1.39)	— —	**1.44 (1.22-1.70)*****	——
Fig 53	D.C. Prior[a]:	— —	— —	— —	— —	**1.94 (1.61-2.34)*****	— —
	U.S.[b]:	— —	— —	— —	**0.40 (0.34-0.47)*****	**0.81 (0.70-0.95)****	— —
Fig 54	D.C. Prior[a]:	— —	— —	— —	— —	0.89 (0.70-1.13)	— —
	U.S.[b]:	— —	— —	0.96 (0.79-1.16)	— —	0.88 (0.72-1.07)	— —
Fig 55	U.S., Always[d]:	— —	— —	— —	— —	**0.40 (0.32-0.51)*****	— —
Fig 56	D.C. Prior[a]:	— —	— —	— —	— —	**1.23 (1.03-1.47)***	— —
	U.S.[b]:	— —	— —	**1.24 (1.06-1.46)****	— —	**1.37 (1.20-1.57)*****	— —
Fig 57	U.S., Gun/ D.C 1993[c]:	— —	— —	— —	— —	**1.65 (1.26-2.16)*****	**0.57 (0.44-0.74)*****
	U.S., Weapon/D.C. 1993[c]:	— —	— —	— —	— —	**1.23 (1.00-1.52)***	**0.54 (0.44-0.66)*****
Fig 62	D.C. Prior[a]:	— —	1.35 (0.98-1.88)	1.21 (0.84-1.73)	0.93 (0.65-1.33)	0.75 (0.56-1.02)	1.14 (0.83-1.57)
	U.S.[b]:	**1.61 (1.25-2.08)*****	**2.08 (1.57-2.75)*****	**2.03 (1.49-2.76)*****	**1.90 (1.50-2.40)*****	**1.51 (1.21-1.89)*****	— —
Fig 63a	D.C. Prior[a]:	— —	— —	— —	— —	**1.35 (1.11-1.63)****	— —
	U.S.[b]:	— —	— —	— —	**1.27 (1.09-1.49)****	**1.38 (1.19-1.61)*****	— —
Fig 63b	D.C. Prior[a]:	— —	— —	— —	— —	— —	— —
	U.S.[b]:	— —	— —	— —	— —	**1.21 (1.01-1.46)***	— —

Figure Title and Location

Figure 52: Percentage of Obese Students, 2003 and 2007, D.C. *versus* National (p. 34)

Figure 53: Students Getting 60 Minutes of Exercise Per Day, 2005 and 2007, D.C. *versus* National (p. 35)

Figure 54: Percentage of Students Who consume Fruits and Vegetables Five or More Times Per Day, 2003 and 2007, D.C. *versus* National (p. 35)

Figure 55: Perception of School Safety, 2007, D.C. *versus* National (p. **Error! Bookmark not defined.**)

Figure 56: High School Students in a Physical Fight One or More Times, 2003 and 2007, D.C. *versus* National (p. **Error! Bookmark not defined.**)

Figure 57: Percentage of High School Students Who Carried a Weapon or Gun in the Last 30 Days, 2007, , D.C. *versus* National (p. 37)

Figure 62: Student Condom Use, 1997 to 2007, D.C. *versus* National (p. 39)

Figure 63: Students with Asthma, D.C. *versus* National, 2005 and 2007 (p. 40)

* denotes p≤.05; ** denotes p≤.01; *** denotes p≤.001.

[a] The odds ratio presented is the comparison of the percentage in a given year (e.g., 2007) to that of the percentage of the prior measurement (e.g., 2005).
[b] The odds ratio presented is the comparison of percentage of students from Washington, D.C. to those of students from the entire United States in a given year.
[c] The odds ratio presented is the comparison of the D.C. percentage in 2007 to the D.C. percentage in 1997 (or, in the case of figure 57, 1993).
[d] The odds ratio presented is the comparison of percentage of students from Washington, D.C. reporting “Always” feeling safe at school to those of students from the entire United States in 2007.

Table 20

Supplemental Odds Ratios for Figures 52 to 63

OR (95% Confidence Interval)

Figure 52: Percentage of Obese Students, Washington, D.C., 2007 *versus* 2003

Black	**1.36 (1.07-1.74)***	*9th Grade*	1.24 (0.86-1.79)
Hispanic	1.39 (0.80-2.41)	*10th Grade*	1.10 (0.77-1.58)
Other	1.50 (0.62-3.64)	*11th Grade*	**2.25 (1.31-5.47)****
Female	**1.45 (1.07-1.96)***	*12th Grade*	1.37 (0.82-2.29)
Male	1.33 (0.97-1.83)		
Female and 11th Grade	**2.69 (1.32-5.47)****		
Female and 12th Grade	1.58 (0.66-3.78)		
Male and 11th Grade	1.86 (0.84-4.09)		

Figure 53: Students Getting 60 Minutes of Exercise Per Day, Washington, D.C., 2007 *versus* 2003

Black	**1.93 (1.57-2.38)*****	*Female*	**2.14 (1.66-2.75)*****
Hispanic	**2.07 (1.18-3.63)***	*Male*	**1.77 (1.35-2.30)*****
Other	1.17 (0.66-2.06)		
Black and Female	**2.10 (1.58-2.78)*****		
Black and Male	**1.85 (1.39-2.47)*****		

Figure 54: Percentage of Students Who consume Fruits and Vegetables Five or More Times Per Day, Washington, D.C.

	2007 v 1999	2003 v 1999	2007 v 2003		2007 v 2003
Black	**0.66 (0.51-0.85)****	**0.76 (0.59-0.97)***	0.87 (0.66-1.15)	*Black and Female*	0.87 (0.63-1.20)
Hispanic	**0.29 (0.17-0.50)*****	**0.39 (0.21-0.72)****	0.75 (0.41-1.36)	*Black and Male*	0.88 (0.60-1.30)
Other	— —	— —	0.85 (0.48-1.50)		

Figure 56: High School Students in Physical Fight One or More Times, Washington, D.C., 2007 *versus* 2003

Black	**1.29 (1.06-1.57)***	*9th Grade*	1.24 (0.93-1.66)
Hispanic	1.04 (0.62-1.73)	*10th Grade*	1.37 (0.92-2.03)
Other	0.99 (0.55-1.80)	*11th Grade*	1.26 (0.86-1.84)
Female	1.27 (1.00-1.61)	*12th Grade*	0.94 (0.56-1.58)
Male	1.19 (0.92-1.55)		
Black and 9th Grade	**1.42 (1.03-1.96)***		
Black and 10th Grade	1.44 (0.94-2.21)		

Figure 57:Percentage of H.S. Student Carrying Weapon in Last 30 Days, Washington, D.C., 2007 *versus* 2005

Black	1.29 (0.99-1.69)	*9th Grade*	**1.43 (1.04-2.10)***
Hispanic	1.03 (0.63-1.69)	*10th Grade*	1.40 (0.97-2.02)
Female	1.09 (0.79-1.52)	*11th Grade*	0.84 (0.52-1.37)
Male	**1.55 (1.14-2.10)****	*12th Grade*	**3.05 (1.41-6.61)****

	2007 v 1993		*2005 v 1993*
Black	**0.50 (0.40-0.63)*****	*Black*	**0.39 (0.31-0.48)*****
Female	**0.52 (0.39-0.69)*****	*Female*	**0.48 (0.37-0.62)*****
Male	**0.54 (0.40-0.72)*****	*Male*	**0.35 (0.27-0.45)*****

Figure 62: Student Condom Use, Washington, D.C., *versus* National, 2007

Female	**1.69 (1.26-2.26)*****	*9th Grade*	1.22 (0.74-2.01)
Male	1.30 (0.84-2.02)	*10th Grade*	**2.26 (1.30-3.91)****
		11th Grade	1.14 (0.74-1.76)

Figure 63: Student with Lifetime Asthma, Washington, D.C., *versus* National, 2007

Female	**1.22 (1.03-1.44)***	*Black*	1.16 (0.94-1.42)
Male	**1.55 (1.23-1.94)*****	*Hispanic*	0.81 (0.48-1.39)

Current Asthma

Female	1.15 (0.91-1.46)	*Black*	0.93 (0.73-1.18)
Male	1.18 (0.88-1.60)	*Hispanic*	0.67 (0.33-1.36)